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
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N BOCA RATON, FL 33428**

(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 03/19/2025 at Menorah House, a nursing home in Boca Raton, 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=E	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 This Statute or Rule is not met as evidenced by:	K 222		4/19/25

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/16/25

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
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N BOCA RATON, FL 33428**

(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 222	Continued From page 1 Based on observations and staff interviews, the facility failed to maintain egress doors equipped with special locking arrangements in accordance with NFPA 101, for 3 of 9 sampled special locking arrangement exit doors. The findings included: On 03/19/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 11:43 AM, the Main Entrance double exit doors, equipped with a delayed egress special locking arrangement, were missing the required signage from both leaves. 2. At 11:55 AM, the Dining Room Patio exit screen door was locked at the latch and a slide lock, located 48 inches above the finished floor, was engaged toward the top of the door. No documentation was provided stating the local authority having jurisdiction approved a clinical needs or security special locking arrangement for multiple locks on a single door. 3. At 1:11 PM, the Rehabilitation double emergency exit doors equipped with a delayed egress special locking arrangement were locked with a hook deadbolt lock. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 101 (2021 Edition) 4.6.12.1, 7.1.9, 7.1.10.1, 7.2.1.5.3.1(2), 7.2.1.5.3.2, 7.2.1.6.1.1(3),	K 222	K K222 NFPA 101 EGRESS DOORS 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of the Main Entrance double doors equipped with delayed egress special locking arrangements, not having the required signage on both doors. Maintenance has installed new signage on both of the front doors 2) In the allegation of the Dining Room patio exit screen door having multiple lock on it. Maintenance has removed the extra lock and there is currently only one. 3) In the allegation of the Rehabilitation double emergency exit doors equipped with delayed egress special locking arrangements being locked with a hook deadbolt lock. Maintenance has disengaged the hook deadbolt lock. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: o Maintenance Director or designee will ensure that proper signage on the Main Entrance double doors is on those doors. o Maintenance Director or designee will ensure that there is only one lock on the Dining Room Patio exit door. o Maintenance Director or designee will ensure that hook deadbolt lock on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 222	Continued From page 2 7.2.1.6.1.1(4), 19.1.1.1.3, 19.2.1, 19.2.2.2.4(1-2), 19.2.2.2.5, 19.2.2.2.6(2) Photographic evidence obtained. Class III	K 222	Rehabilitation double emergency exit doors is disengaged. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	
K 324 SS=E	NFPA 101 Cooking Facilities Cooking Facilities Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. Commercial cooking operations shall be protected in accordance with NFPA 96 unless such installations are approved existing installations, which shall be permitted to be continued in service. 18.3.2.5.1 through 18.3.2.5.5, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3 This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their commercial cooking facility in accordance with NFPA 101, for 2 of 3 sampled gas-powered cooking appliances on	K 324	K324 NFPA 101 COOKING FACILITIES 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:	4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 324	Continued From page 3 castors. The findings included: On 03/19/2025, at 12:33 PM, during the fire safety tour of the facility with the Maintenance Director, the dairy side of the Kitchen had two gas-powered appliances, a steamer and an oven, on castors without the means to prevent strain on the gas connection. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 54 (2021 Edition) 10.11.6 NFPA 96 (2021 Edition) 5.1.4, 10.2.6, 12.2.1 NFPA 101 (2021 Edition) 2.1, 4.5.8, 4.6.12.1, 9.2.3, 19.3.2.5.1 Photographic evidence obtained. Class III	K 324	In the allegation of the two gas powered appliances on the dairy side of the kitchen, a steamer and an oven, on castors without the means to prevent strain on the gas connection. Maintenance has added restraints to the steamer and the oven to keep them from moving and putting strain on the gas connection. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance Director or designee will put proper restraints on the gas powered steamer and oven on the dairy to keep them from putting strain on the gas connection. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 324	Continued From page 4	K 324	ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system. 19.7.6, 4.6.12, 4.6.12.1, 9.11 through 9.11.3.2, and NFPA 25 This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain their automatic fire sprinkler system in accordance with NFPA 101, for 1 of 1 fire department connection and 1 of 1 fire-line backflow preventer. The findings included: On 03/19/2025 between 10:00 AM and 2:00 PM during record review with the Maintenance Assistant, the following were revealed: 1. No documentation was provided for the FDC 5-year hydrostatic test. 2. No documentation was provided for the fire-line backflow preventer 5-year internal inspection.	K 353	K353 NFPA 101 SPRINKLER SYSTEM – MAINTENANCE AND TESTING 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of having no documentation for the FDC 5-year hydrostatic test. The Maintenance Director or designee will acquire the documentation of proof that the FDC 5-year hydrostatic test was completed 2) In the allegation of having no documentation for the fire-line backflow preventer 5-year internal inspection. The Maintenance Director or designee will acquire the documentation of proof that	4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 353	Continued From page 5 An interview was conducted with the Maintenance Assistant concurrent with the record review and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 1 (2021 Edition) 13.3.1.2, 13.3.3.2 NFPA 13 (2019 Edition) 31.1 NFPA 25 (2020 Edition) 4.3.1, 5.1.1.2, 6.3.2.1, 13.8.5, 13.7.1.3 NFPA 101 (2021 Edition) 4.6.12, 4.6.12.1, 9.7, 19.3.5, 19.7.6 Class III	K 353	the fire-line backflow preventer 5-year internal inspection was completed 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: o Maintenance Director or designee will ensure that there is proper documentation for the FDC 5-year hydrostatic test is up to date and available for inspection. o Maintenance Director of designee will ensure that there is proper documentation for the fire-line backflow preventer 5-year internal inspection documentation is up to date and available for inspection. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 355 SS=D	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 3 of 12 sampled portable fire extinguishers. The findings included: On 03/19/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 12:00 PM, the Telecommunication Equipment Room class ABC fire extinguisher was obstructed by equipment. 2. At 12:02 PM, the Telecommunication Equipment Room did not have a clean agent fire extinguisher. 3. At 12:55 PM, the fire extinguisher near Room 203 was obstructed by a cart. 4. At 1:22 PM, the fire extinguisher near Room 209 was obstructed by a cart. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on	K 355	K355 NFPA 101 PORTABLE FIRE EXTINGUISHERS 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of ABC fire extinguisher in the Telecommunication Equipment Room being obstructed by equipment. Maintenance has moved items around to ensure that the ABC fire extinguisher is unobstructed. 2) In the allegation of the Telecommunications room not having a clean agent fire extinguisher. Maintenance will place a clean agent fire extinguisher in the Telecommunication room 3) In the allegation of the fire extinguisher near room 203 being obstructed by a cart. The cart was moved. An in-service will be done for the staff not to place carts in front of fire extinguishers. 4) In the allegation of the fire extinguisher near room 209 being obstructed by a cart. The cart was moved. An in-service will be done for the staff not to place carts in front of fire extinguishers. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action	4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 355	Continued From page 7 03/19/2025 at 3:15 PM. NFPA 10 (2018 Edition) 5.3.2.6, 5.5.6, 5.5.6.1, 6.1.3.1, 6.1.3.3.1 NFPA 99 (2021 Edition) 16.10.1, 16.10.1.5 NFPA 101 (2021 Edition) 9.9, 19.3.5.12 Photographic evidence obtained. Class III	K 355	will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: o Maintenance will ensure that in Telecommunication room that the ABC fire extinguisher is not obstructed. o Maintenance will put a Clean agent fire extinguisher in the Telecommunication room. o Maintenance will in-service staff not to place carts in front of fire extinguishers. o Maintenance will ensure that carts are not placed in front of fire extinguishers during rounds. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie	K 372		4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 372	Continued From page 8 Subdivision of Building Spaces - Smoke Barrier Construction 2021 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3 through 19.3.7.5.2, 8.5 2021 NEW Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, in which case both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2) Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems. (3) The provisions of 8.5.6.5 and 8.5.7.2 shall not apply. 18.3.7.3 through 18.8.7.5.2, 8.5 For other than existing assemblies, where there is an accessible concealed floor, floor/ceiling, or attic space, fire barriers, smoke barriers, and smoke partitions shall be permanently identified	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N BOCA RATON, FL 33428**

(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 372	Continued From page 9 with signs or stenciling in the concealed space and shall comply with all of the following: " (1) Be located in accessible concealed floor, floor/ceiling, or attic spaces. " (2) Be located within 15 ft (4572 mm) of the end of each wall and at intervals not exceeding 30 ft (9144 mm) measured horizontally along the wall or partition. " (3) Include lettering not less than 3 in. (76 mm) in height with a minimum 3?8 in. (9.5 mm) stroke in a contrasting color. " (4) Identify the wall type and its fire resistance rating, as applicable. 8.2.2.5 This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain their Fire/Smoke barrier construction in accordance with NFPA 101, for 2 of 4 sampled Fire/Smoke barriers. The findings included: On 03/19/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 12:52 PM, the Galilee wing, near Room 233, had one penetration through both sides of the 2-hour fire rated wall. 2. At 2:09 PM, the Masada wing, near Room 127, had one penetration through both sides of the smoke wall. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the	K 372	K372 NFPA 101 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of the Galilee wing, near room 233 having one penetration through both sides of the smoke wall. Maintenance will seal the penetration with Red Fire Caulk. 2) In the allegation of the Masada wing, near room 127 having one penetration through both sides of the smoke wall. Maintenance will seal the penetration with Red Fire Caulk. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 372	Continued From page 10 Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NOTE: These examples are not to be considered as the only unprotected penetration of the facility's fire/smoke barriers. A thorough inspection of each barrier shall be made along its full length and height to ensure that all penetrations are found and properly sealed. It is required that every breach (penetration) of a fire barrier be appropriately repaired and the wall, ceiling, floor above or below brought back to its original fire or smoke rated integrity. This is essential to restrict the movement of fire and smoke and to ensure the safety of occupants within the facility in a fire emergency. The penetrations in fire rated barriers shall be sealed with a UL (Underwriters Laboratories) listed approved system. NFPA 101 (2021 Edition) 4.6.12.1, 8.3.4, 8.3.4.2.1, 8.4.4, 8.4.6.2, 8.5.5.2, 8.5.5.4.1, 8.5.5.4.2, 8.5.6.2, 19.1.1.1.3, 19.3.7.5, 19.7.6 Photographic evidence obtained. Class III	K 372	3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance will seal the alleged penetration in the smoke walls with Red Fire caulk. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	
K 900 SS=F	NFPA 99 Health Care Facilities Code - Other Health Care Facilities Code - Other List in the REMARKS section any NFPA 99 requirements (including Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included. This Statute or Rule is not met as evidenced by:	K 900		4/19/25

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
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N BOCA RATON, FL 33428**

(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 900	Continued From page 11 Based on observations and staff interview, the facility failed to maintain its nurse call system in accordance with NFPA 99, for 2 of 2 sampled nurse call systems. The findings included: On 03/19/2025, between 12:55 PM and 2:25 PM, during the fire safety tour of the facility with the Maintenance Director, it was observed that the Galilee wing nurse call system had two corridor lights that were not illuminating and the Masada wing nurse call system had three corridor lights that were not illuminating when tested. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 99 (2021 Edition) 7.3.3.1.1, 7.3.3.1.8.2(2) Class III	K 900	K900 NFPA 99 HEALTH CARE FACILITIES CODE – OTHER 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: In the allegation that the Galilee wing nurse call system having two corridor lights that were allegedly not illuminating and the Masada wing nurse call system having three corridor lights that were allegedly not illuminating. The maintenance staff will check those nurse call light corridor lights allegedly not working and do any necessary repairs to ensure they are illuminating properly. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance will check those nurse call light corridor light allegedly not working and do any necessary repairs to ensure they are illuminating properly. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 900	Continued From page 12	K 900	compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	
K 918 SS=F	NFPA 99 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40-day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions includes a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 918	Continued From page 13 readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.9.1, 6.9.2, 6.9.3, 6.9.4, 6.10.18, 6.11 through 6.11.4.4 (NFPA 99), NFPA 110, NFPA 111, NFPA 70 This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the Essential Electrical System (EES) in accordance with NFPA 99, for 1 of 1 Essential Electrical Systems. The findings included: On 03/19/2025, at 12:13 PM, during the fire safety tour of the facility with the Maintenance Director, it was revealed that there was not a supply of generator replacement parts for high mortality items on premises. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 99 (2021 Edition) 6.7.1.2.1, 6.7.4.1.1.3, 6.7.4.2, 6.7.4.1.2.3 NFPA 101 (2021 Edition) 2.1, 9.1.3.1, 19.5.1.1, 19.5.1.3 NFPA 110 (2019 Edition) 8.1, 8.2.4, 8.2.4.1, 8.5 Class III	K 918	K918 NFPA 99 ELECTRICAL SYSTEMS -- ESSENTIAL ELECTRICAL SYSTEM 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: In the allegation of the facility not having a supply of generator parts for high mortality items on premises. Maintenance staff will obtain and keep on site generator parts that have a high mortality rate. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance will obtain and keep on site generator parts that have a high mortality rate. 4. How the corrective action(s) will be monitored to ensure the practice will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 918	Continued From page 14	K 918	recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	
K 920 SS=E	NFPA 99 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for	K 920		4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N BOCA RATON, FL 33428**

(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 920	Continued From page 15 which it was installed and meets the conditions of 10.2.4. 10.2.3.6, 10.2.4, 10.5.2.3 (NFPA 99), NFPA 70 This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to install ground-fault circuit-interrupter (GFCI) and prevent the improper use of power strips utilized in lieu of permanent wiring in accordance with NFPA 99, for 2 of 3 compartments. The findings included: On 03/19/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 11:49 AM, the Reception desk had a power strip plugged into a power strip, instead of directly into a wall receptacle. 2. At 12:02 PM, the Telecommunication Room had a power strip plugged into a power strip, instead of directly into a wall receptacle. 3. At 12:39 PM, the Service Corridor had two vending machines, one of which did not have GFCI protection. 4. At 2:15 PM, Room 122 had a television plugged into a power strip, which was within six of the patient care area. 5. At 2:17 PM, Room 123 had a television plugged into a power strip, which was within six of the patient care area. 6. At 2:35 PM, Room 128 had a television plugged into a power strip, which was within six of	K 920	K920 NFPA 99 ELECTRICAL EQUIPMENT – POWER CORDS AND EXTENTION CORDS 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of the Reception Desk using power strip and not plugging directly into the wall receptacle. Maintenance staff will remove the power strip and plug items directly into the wall receptacle. 2) In the allegation of the Telecommunication Room using power strip and not plugging directly into the wall receptacle. Maintenance staff will remove the power strip and plug items directly into the wall receptacle. 3) In the allegation of the Service Corridor having a vending machine without GFCI protection, maintenance will add GFCI protection for that vending machine. 4) In the allegation of Room 122 using a power strip for the television. Maintenance staff will remove the power strip and plug the television directly into the wall receptacle. 5) In the allegation of Room 123 using a power strip for the television. Maintenance staff will remove the power strip and plug the television directly into the wall receptacle. 6) In the allegation of Room 128 using a power strip for the television. Maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N BOCA RATON, FL 33428**

(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 920	Continued From page 16 the patient care area. 7. At 2:38 PM, Room 104 had a television plugged into a power strip, which was within six of the patient care area. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 1 (2021 Edition) 11.1.2.1, 11.1.3.2, 11.1.4.2 NFPA 70 (2020 Edition) 110.3(B), 400.5(A), 400.12(1), 422.5(A)(5) NFPA 99 (2021 Edition) 10.1, 10.2.3.1.1, 10.2.3.6, 10.4.2.3 NFPA 101 (2021 Edition) 2.1, 9.1.2, 19.5.1.1, 19.5.1.3 Photographic evidence obtained. Class III	K 920	staff will remove the power strip and plug the television directly into the wall receptacle. 7) In the allegation of Room 104 using a power strip for the television. Maintenance staff will remove the power strip and plug the television directly into the wall receptacle. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: o Maintenance will ensure that power strips are not being used where they should not be used and items are plugged directly into the wall receptacle. o Maintenance will ensure that items that need GFCI protection have GFCI protection. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95039	A. BUILDING: **06 - MAIN LIC** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 920	Continued From page 17	K 920	ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted on 03/19/2025 at Menorah House, a nursing home in Boca Raton, Florida. Menorah House 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: 1988, 1996 Existing NFPA 220 Construction Type: II (111) Number of beds: 120 Census: 111 The following is a description of the noncompliance.	K 000		
K 222 SS=E	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 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	K 222		4/19/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/16/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 222	Continued From page 1 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 by an approved, supervised automatic fire detection system and an approved, supervised	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 222	Continued From page 2 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 special locking arrangements in accordance with NFPA 101, for 3 of 9 sampled special locking arrangement exit doors. The findings included: On 03/19/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 11:43 AM, the Main Entrance double exit doors, equipped with a delayed egress special locking arrangement, were missing the required signage from both leaves. 2. At 11:55 AM, the Dining Room Patio exit screen door was locked at the latch and a slide lock, located 48 inches above the finished floor, was engaged toward the top of the door. No documentation was provided stating the local authority having jurisdiction approved a clinical needs or security special locking arrangement for multiple locks on a single door. 3. At 1:11 PM, the Rehabilitation double emergency exit doors equipped with a delayed egress special locking arrangement were locked with a hook deadbolt lock. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the	K 222	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. K222 EGRESS DOORS 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of the Main Entrance double doors equipped with delayed egress special locking arrangements, not having the required signage on both doors. Maintenance has installed new signage on both of the front doors 2) In the allegation of the Dining Room patio exit screen door having multiple lock on it. Maintenance has removed the extra lock and there is currently only one. 3) In the allegation of the Rehabilitation double emergency exit doors equipped with delayed egress special locking arrangements being locked with a hook deadbolt lock. Maintenance has disengaged the hook deadbolt lock. 2. How you will identify other residents having potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 222	Continued From page 3 Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 101 (2012 Edition) 4.6.12.1, 7.1.9, 7.1.10.1, 7.2.1.5.3.1(2), 7.2.1.5.3.2, 7.2.1.6.1.1(3), 7.2.1.6.1.1(4), 19.1.1.1.3, 19.2.1, 19.2.2.2.4(1-2), 19.2.2.2.5, 19.2.2.2.6(2) Photographic evidence obtained.	K 222	same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: o Maintenance Director or designee will ensure that proper signage on the Main Entrance double doors is on those doors. o Maintenance Director or designee will ensure that there is only one lock on the Dining Room Patio exit door. o Maintenance Director or designee will ensure that hook deadbolt lock on the Rehabilitation double emergency exit doors is disengaged. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101	K 324		4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 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 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. 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. 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their commercial cooking facility in accordance with NFPA 101, for 2 of 3 sampled gas-powered cooking appliances on castors. The findings included: On 03/19/2025, at 12:33 PM, during the fire safety tour of the facility with the Maintenance	K 324	K324 COOKING FACILITIES 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: In the allegation of the two gas powered appliances on the dairy side of the kitchen, a steamer and an oven, on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 5 Director, the dairy side of the Kitchen had two gas-powered appliances, a steamer and an oven, on castors without the means to prevent strain on the gas connection. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 54 (2012 Edition) 10.12.6 NFPA 96 (2011 Edition) 5.1.4, 10.2.6, 12.2.1 NFPA 101 (2012 Edition) 2.1, 4.5.8, 4.6.12.1, 9.2.3, 19.3.2.5.1 Photographic evidence obtained.	K 324	castors without the means to prevent strain on the gas connection. Maintenance has added restraints to the steamer and the oven to keep them from moving and putting strain on the gas connection. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance Director or designee will put proper restraints on the gas powered steamer and oven on the dairy to keep them from putting strain on the gas connection. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 6	K 324		
K 355 SS=D	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 3 of 12 sampled portable fire extinguishers. The findings included: On 03/19/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 12:00 PM, the Telecommunication Equipment Room class ABC fire extinguisher was obstructed by equipment. 2. At 12:02 PM, the Telecommunication Equipment Room did not have a clean agent fire extinguisher. 3. At 12:55 PM, the fire extinguisher near Room 203 was obstructed by a cart. 4. At 1:22 PM, the fire extinguisher near Room 209 was obstructed by a cart.	K 355	Corrective action completion date: 4/19/25 K355 PORTABLE FIRE EXTINGUISHERS 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of ABC fire extinguisher in the Telecommunication Equipment Room being obstructed by equipment. Maintenance has moved items around to ensure that the ABC fire extinguisher is unobstructed. 2) In the allegation of the Telecommunications room not having a clean agent fire extinguisher. Maintenance will place a clean agent fire extinguisher in the Telecommunication room 3) In the allegation of the fire extinguisher near room 203 being obstructed by a cart. The cart was moved. An in-service will be done for the staff not to place carts in front of fire extinguishers. 4) In the allegation of the fire extinguisher near room 209 being	4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N BOCA RATON, FL 33428**

(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 355	Continued From page 7 An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 10 (2010 Edition) 5.3.2.6, 5.5.6, 5.5.6.1, 6.1.3.1, 6.1.3.3.1 NFPA 99 (2012 Edition) 16.10.1, 16.10.1.5 NFPA 101 (2012 Edition) 9.9, 19.3.5.12 Photographic evidence obtained.	K 355	obstructed by a cart. The cart was moved. An in-service will be done for the staff not to place carts in front of fire extinguishers. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: o Maintenance will ensure that in Telecommunication room that the ABC fire extinguisher is not obstructed. o Maintenance will put a Clean agent fire extinguisher in the Telecommunication room. o Maintenance will in-service staff not to place carts in front of fire extinguishers. o Maintenance will ensure that carts are not placed in front of fire extinguishers during rounds. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 355	Continued From page 8	K 355	the plan of correction. Corrective action completion date: 4/19/25	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain their Fire/Smoke barrier construction in accordance with NFPA 101, for 2 of 4 sampled Fire/Smoke barriers. The findings included: On 03/19/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 12:52 PM, the Galilee wing, near Room 233, had one penetration through both sides of the 2-hour fire rated wall. 2. At 2:09 PM, the Masada wing, near Room 127,	K 372	K372 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of the Galilee wing, near room 233 having one penetration through both sides of the smoke wall. Maintenance will seal the penetration with Red Fire Caulk. 2) In the allegation of the Masada wing, near room 127 having one penetration through both sides of the smoke wall. Maintenance will seal the penetration with Red Fire Caulk.	4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 372	Continued From page 9 had one penetration through both sides of the smoke wall. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NOTE: These examples are not to be considered as the only unprotected penetration of the facility's fire/smoke barriers. A thorough inspection of each barrier shall be made along its full length and height to ensure that all penetrations are found and properly sealed. It is required that every breach (penetration) of a fire barrier be appropriately repaired and the wall, ceiling, floor above or below brought back to its original fire or smoke rated integrity. This is essential to restrict the movement of fire and smoke and to ensure the safety of occupants within the facility in a fire emergency. The penetrations in fire rated barriers shall be sealed with a UL (Underwriters Laboratories) listed approved system. NFPA 101 (2012 Edition) 4.6.12.1, 8.3.4, 8.3.4.2.1, 8.4.4, 8.4.6.2, 8.5.5.2, 8.5.5.4.1, 8.5.5.4.2, 8.5.6.2, 19.1.1.1.3, 19.3.7.5, 19.7.6 Photographic evidence obtained.	K 372	2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance will seal the alleged penetration in the smoke walls with Red Fire caulk. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 918	Continued From page 10 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the Essential Electrical System (EES) in accordance with NFPA 99, for 1 of 1 Essential Electrical Systems. The findings included:	K 918	K918 ELECTRICAL SYSTEMS – ESSENTIAL ELECTRICAL SYSTEM 1. What corrective action(s) will be accomplished for those residents found to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 918	Continued From page 11 On 03/19/2025, at 12:13 PM, during the fire safety tour of the facility with the Maintenance Director, it was revealed that there was not a supply of generator replacement parts for high mortality items on premises. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 99 (2012 Edition) 6.7.1.2.1, 6.7.4.1.1.3, 6.7.4.2, 6.7.4.1.2.3 NFPA 101 (2012 Edition) 2.1, 9.1.3.1, 19.5.1.1, 19.5.1.3 NFPA 110 (2010 Edition) 8.1, 8.2.4, 8.2.4.1, 8.5	K 918	have been affected by the practice: In the allegation of the facility not having a supply of generator parts for high mortality items on premises. Maintenance staff will obtain and keep on site generator parts that have a high mortality rate. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance will obtain and keep on site generator parts that have a high mortality rate. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to install ground-fault circuit-interrupter (GFCI) and prevent the improper use of power strips utilized in lieu of permanent wiring in accordance with NFPA 99, for 2 of 3 compartments. The findings included: On 03/19/2025, at the following times, during the fire safety tour of the facility with the Maintenance	K 920	K920 ELECTRICAL EQUIPMENT – POWER CORDS AND EXTENTION CORDS 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1) In the allegation of the Reception Desk using power strip and not plugging directly into the wall receptacle.	4/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 920	Continued From page 13 Director, the following was observed: 1. At 11:49 AM, the Reception desk had a power strip plugged into a power strip, instead of directly into a wall receptacle. 2. At 12:02 PM, the Telecommunication Room had a power strip plugged into a power strip, instead of directly into a wall receptacle. 3. At 12:39 PM, the Service Corridor had two vending machines, one of which did not have GFCI protection. 4. At 2:15 PM, Room 122 had a television plugged into a power strip, which was within six of the patient care area. 5. At 2:17 PM, Room 123 had a television plugged into a power strip, which was within six of the patient care area. 6. At 2:35 PM, Room 128 had a television plugged into a power strip, which was within six of the patient care area. 7. At 2:38 PM, Room 104 had a television plugged into a power strip, which was within six of the patient care area. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 03/19/2025 at 3:15 PM. NFPA 70 (2011 Edition) 110.3(B), 400.5(A), 400.8(1), 422.51	K 920	Maintenance staff will remove the power strip and plug items directly into the wall receptacle. 2) In the allegation of the Telecommunication Room using power strip and not plugging directly into the wall receptacle. Maintenance staff will remove the power strip and plug items directly into the wall receptacle. 3) In the allegation of the Service Corridor having a vending machine without GFCI protection, maintenance will add GFCI protection for that vending machine. 4) In the allegation of Room 122 using a power strip for the television. Maintenance staff will remove the power strip and plug the television directly into the wall receptacle. 5) In the allegation of Room 123 using a power strip for the television. Maintenance staff will remove the power strip and plug the television directly into the wall receptacle. 6) In the allegation of Room 128 using a power strip for the television. Maintenance staff will remove the power strip and plug the television directly into the wall receptacle. 7) In the allegation of Room 104 using a power strip for the television. Maintenance staff will remove the power strip and plug the television directly into the wall receptacle. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING **01 - MAIN FED** B. WING	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	**9945 CENTRAL PARK BLVD N** **BOCA RATON, FL 33428**

(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 920	Continued From page 14 NFPA 99 (2012 Edition) 10.1, 10.2.3.1.1, 10.2.3.6, 10.4.2.3 NFPA 101 (2012 Edition) 2.1, 9.1.2, 19.5.1.1, 19.5.1.3 Photographic evidence obtained.	K 920	All residents in the facility have the potential to be affected by these practices. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: o Maintenance will ensure that power strips are not being used where they should not be used and items are plugged directly into the wall receptacle. o Maintenance will ensure that items that need GFCI protection have GFCI protection. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Maintenance or a qualified Designee, will monitor for substantial compliance. Findings of the audits will be reported at the Monthly QAPI meeting by the Director of Maintenance or a qualified Designee to ensure effectiveness and compliance of the plan of correction. Corrective action completion date: 4/19/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. BUILDING _____ B. WING _____	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENORAH HOUSE	9945 CENTRAL PARK BLVD N BOCA RATON, FL 33428

(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 Fire & Life Safety Recertification survey, conducted on 03/19/2025 at Menorah House, a nursing home, Emergency Preparedness was reviewed. Menorah House 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 | 04/16/2025

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.