

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 95044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2025
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NAME OF PROVIDER OR SUPPLIER BOCA CIRCLE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7225 BOCA DEL MAR DRIVE BOCA RATON, FL 33433
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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K 000	<p>INITIAL COMMENTS</p> <p>An unannounced Fire & Life Safety Relicensure survey was conducted on 02/04/2025 at Boca Circle Rehabilitation Center, 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.</p> <p>The following is a description of the deficiencies found at the time of the visit.</p>	K 000		
K 222 SS=E	<p>NFPA 101 Egress Doors</p> <p>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:</p> <ul style="list-style-type: none"> (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. <p>18.2.2.2.4 through 18.2.2.2.7, 19.2.2.2.4 through 19.2.2.2.7</p> <p>This Statute or Rule is not met as evidenced by:</p>	K 222		3/6/25

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/26/25
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K 222	<p>Continued From page 1</p> <p>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 4 of 15 sampled delayed egress doors.</p> <p>The findings included:</p> <p>On 02/04/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed:</p> <ol style="list-style-type: none"> At 10:05 AM, the 500 Hallway Lobby double exit doors equipped with 30-second delayed egress locks were missing the required signage on both leaves. At 11:12 AM, the Main Lobby double interior egress doors equipped with 30-second delayed egress locks were missing the required signage from both leaves. At 11:16 AM, the Main Lobby double-interior-egress doors equipped with 30-second delayed egress locks were missing the required signage from the left leaf. At 11:33 AM, the Therapy Lobby double exit doors equipped with 30-second delayed egress locks failed to open when tested, both leaves. <p>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, the Regional Maintenance Director at the exit conference on 02/04/2025 at 2:40 PM.</p> <p>NFPA 101 (2021 Edition) 7.1.9, 7.2.1.6.1.1(3)</p>	K 222	<p>Corrective Actions</p> <ol style="list-style-type: none"> The following egress doors had signage added to indicate the presence of a 30 second delayed egress locking arrangement on 2/5/2025. <ul style="list-style-type: none"> A. 500 Hallway Lobby double exit doors. (30 second Delay Signage) B. Main Lobby double interior egress doors. (15 second Delay Signage) C. Main Lobby double interior egress doors, left leaf. (15 second Delay Signage) The Therapy Lobby double exit doors were evaluated and made to function properly when the delayed egress locking arrangement was initiated on 2/5/2025. <p>Identification of Others Potentially Affected</p> <p>The Maintenance Director, or designee, performed a facility-wide assessment of the other egress doors to ensure the following:</p> <ol style="list-style-type: none"> Doors with a delayed egress locking arrangement had the correct signage. Doors with a delayed egress locking arrangement functioned properly. <p>Systemic Changes</p> <p>The Maintenance Director, or designee, will continue to perform documented monthly inspections of all egress doors</p>	

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K 222	Continued From page 2 (a-d), 7.2.1.6.1.1(4)(a), 19.2.1, 19.2.2.2.4(2) Class III	K 222	with a delayed egress locking arrangement to ensure the correct signage is in place, and to ensure the doors properly function, on an ongoing basis as part of the facility's life safety program. Quality Assurance Results of the monthly egress door 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.	
K 324 SS=F	NFFA 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 NFFA 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 NFFA 101, for 1 of 1 sampled commercial cooking hood suppression systems. The findings included:	K 324	Corrective Actions The facility's kitchen hood seams were sealed to ensure that the kitchen hood was grease tight on 2/5/2025. Identification of Others Potentially Affected	3/6/25

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K 324	Continued From page 3 On 02/04/2025, at 11:09 AM, during the fire safety tour of the facility with Maintenance Director, the Kitchen commercial cooking hood suppression system's seams were not sealed or otherwise made greasetight. 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 02/04/2025 at 2:40 PM. NFPA 96 (2021 Edition) 5.1.4, 10.2.6 NFPA 101 (2021 Edition) 2.1, 4.5.8, 4.6.12.1, 9.2.3, 19.3.2.5.1 Class III	K 324	The facility only has one kitchen hood, so no further evaluations are needed. Systemic Changes The Maintenance Director, or designee, will continue to perform documented monthly inspections of the facility's kitchen hood to ensure the kitchen hood seams remain sealed and grease tight on an ongoing basis as part of the facility's life safety program. Quality Assurance Results of the monthly kitchen hood 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.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie 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.	K 372		3/6/25

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K 372	Continued From page 4 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 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	K 372		

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K 372	<p>Continued From page 5</p> <p>rating, as applicable.</p> <p>8.2.2.5</p> <p>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 7 sampled compartments.</p> <p>The findings included:</p> <p>On 02/04/2025, at the following times, during record review and the fire safety tour of the facility with the Regional Maintenance Director and the Maintenance Director, the following was observed:</p> <ol style="list-style-type: none"> At 11:58 AM, the 100 Hallway had one penetration through both sides of the 1-hour smoke wall, above the ceiling of the double fire rated doors. At 12:10 PM, the 300 Hallway had one penetration through both sides of the 1-hour smoke wall, above the ceiling of the double smoke doors. <p>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 02/04/2025 at 2:40 PM.</p> <p>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</p>	K 372	<p>Corrective Actions</p> <p>The following locations had penetrations sealed with fire stopping on 2/5/2025.</p> <ol style="list-style-type: none"> 100 Hallway smoke barrier. 300 Hallway smoke barrier. <p>Identification of Others Potentially Affected</p> <p>The Maintenance Director, or designee, performed a facility-wide assessment of the other fire and smoke barriers to ensure all penetrations are sealed with fire stopping.</p> <p>Systemic Changes</p> <p>The Maintenance Director, or designee, will perform monthly inspections X 3 months of the fire and smoke barriers to ensure all penetrations are sealed with fire stopping. Inspections will continue semi-annually thereafter on an ongoing basis as part of the facility's life safety program.</p> <p>Quality Assurance</p> <p>Results of the monthly fire and smoke barrier inspections will be presented at the monthly QA meetings X 3 months. If substantial compliance is not met after 3</p>	

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K 372	Continued From page 6 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 Class III	K 372	months, monthly inspections will continue, and results will be brought to QA meetings until substantial compliance is met.	
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	K 918		3/6/25

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K 918	<p>Continued From page 7</p> <p>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 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</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain and test their Essential Electrical System, in accordance with NFPA 99, for 2 of 2 generator batteries.</p> <p>The findings included:</p> <p>On 02/04/2025 between 10:00 AM and 1:30 PM, during record review with the Regional Director of Maintenance, the following was identified:</p> <ol style="list-style-type: none"> 1. No documentation was provided for weekly voltage checks for 2 of 2 generator batteries. 2. No documentation was provided for monthly sealed battery conductance tests for 2 of 2 generator batteries. <p>An interview was conducted with the Regional Director of Maintenance concurrent with the</p>	K 918	<p>K918</p> <p>Corrective Actions</p> <p>The following actions occurred on 2/17/2025.</p> <p>A. The weekly generator inspection form was updated to include a battery voltage reading for both generator batteries.</p> <p>B. The monthly generator inspection form was updated to include a battery conductance reading for both generator batteries.</p> <p>Identification of Others Potentially Affected</p> <p>Both facility generator batteries were accounted for, so no further evaluation</p>	

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K 918	Continued From page 8 record review and he acknowledged the findings. NFPA 99 (2012 Edition) 6.4.1.1.13 NFPA 110 (2010 Edition) 8.3, 8.3.7, 8.3.7.1 Class III	K 918	was needed. Systemic Changes The Maintenance Director, or designee, will continue to perform documented weekly generator inspections to include documentation of the battery voltage, and monthly generator testing to include documentation of the battery conductance testing, on an ongoing basis as part of the facility's life safety program. Quality Assurance Results of the weekly inspections and monthly battery testing will be presented at the monthly QA meetings X 3 months. If substantial compliance is not met after 3 months, monthly inspections will continue, and results will be brought to QA meetings until substantial compliance is met.	

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ZZ830 SS=F	<p>408.821 FS Emergency Management Planning</p> <p>408.821 Emergency management planning; emergency operations; inactive license.-</p> <p>(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:</p> <p>(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.</p> <p>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.</p> <p>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.</p> <p>(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.</p> <p>(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.</p> <p>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider</p>	ZZ830		3/6/25

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Electronically Signed

02/26/25

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ZZ830	<p>Continued From page 1</p> <p>is located in a geographic area in which a state of emergency was declared by the Governor if the provider:</p> <ol style="list-style-type: none"> 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. <p>(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.</p> <p>(4) . . . Licensees providing residential or inpatient services must utilize an online database</p>	ZZ830		
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ZZ830	<p>Continued From page 2</p> <p>approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility is not in compliance with the Comprehensive Emergency Management Plan (CEMP).</p> <p>The findings included:</p> <p>On 02/04/2025 between 10:00 AM and 1:00 PM, during record review with the Regional Director of Maintenance, it was identified that the last approved CEMP was dated 12/05/2023, with an expiration of 09/30/2024. The facility submitted their CEMP to the county on 10/30/24. The CEMP was rejected on 12/12/2024. The facility is overdue for resubmission of their CEMP to the county.</p> <p>An interview was conducted with the Regional Director of Maintenance concurrent with the record review and acknowledged the findings.</p> <p>Florida Administrative Code 59A-4.126.</p> <p>Class III</p>	ZZ830	<p>Corrective Actions</p> <p>The facility's Comprehensive Emergency Management Plan (CEMP) was resubmitted to the county for approval on 2/27/2025.</p> <p>Identification of Others Potentially Affected</p> <p>Th facility only has one CEMP, so no further evaluation was needed.</p> <p>Systemic Changes</p> <p>The Administrator, or designee, will continue to submit the facility CEMP to the county annually for approval on an ongoing basis as part of the facility's emergency management program.</p> <p>Quality Assurance</p> <p>Progress of the county approval of the CEMP will be presented at the monthly QA meeting until the CEMP is improved and substantial compliance is met.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105852	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER BOCA CIRCLE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7225 BOCA DEL MAR DRIVE BOCA RATON, FL 33433	
(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	<p>INITIAL COMMENTS</p> <p>An unannounced Fire & Life Safety Recertification survey was conducted on 02/04/2025 at Boca Circle Rehabilitation Center, a nursing home in Boca Raton, Florida. Boca Circle 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.</p> <p>Initial Plan Review: 1993 Existing NFPA 220 Construction Type: II (000) Number of beds: 120 Census: 116</p> <p>The following is a description of the noncompliance.</p>	K 000		
K 222 SS=E	<p>Egress Doors CFR(s): NFPA 101</p> <p>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.</p>	K 222		3/6/25

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

TITLE

(X6) DATE

Electronically Signed

02/26/2025

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	<p>Continued From page 1</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	K 222		

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K 222	<p>Continued From page 2</p> <p>detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>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 4 of 15 sampled delayed egress doors.</p> <p>The findings included:</p> <p>On 02/04/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed:</p> <ol style="list-style-type: none"> At 10:05 AM, the 500 Hallway Lobby double exit doors equipped with 30-second delayed egress locks were missing the required signage on both leaves. At 11:12 AM, the Main Lobby double interior egress doors equipped with 30-second delayed egress locks were missing the required signage from both leaves. At 11:16 AM, the Main Lobby double-interior-egress doors equipped with 30-second delayed egress locks were missing the required signage from the left leaf. At 11:33 AM, the Therapy Lobby double exit doors equipped with 30-second delayed egress locks failed to open when tested, both leaves. <p>An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were</p>	K 222	<p>K222</p> <p>Corrective Actions</p> <ol style="list-style-type: none"> The following egress doors had signage added to indicate the presence of a 30 second delayed egress locking arrangement on 2/5/2025. <ul style="list-style-type: none"> A. 500 Hallway Lobby double exit doors. (30 second Delay Signage) B. Main Lobby double interior egress doors. (15 second Delay Signage) C. Main Lobby double interior egress doors, left leaf. (15 second Delay Signage) The Therapy Lobby double exit doors were evaluated and made to function properly when the delayed egress locking arrangement was initiated on 2/5/2025. <p>Identification of Others Potentially Affected</p> <p>The Maintenance Director, or designee, performed a facility-wide assessment of the other egress doors to ensure the following:</p> <ol style="list-style-type: none"> Doors with a delayed egress locking arrangement had the correct signage. 	

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K 222	Continued From page 3 reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 02/04/2025 at 2:40 PM. NFPA 101 (2012 Edition) 7.1.9, 7.2.1.6.1.1(3) (a-d), 7.2.1.6.1.1(4), 19.2.1, 19.2.2.2.4(2)	K 222	2. Doors with a delayed egress locking arrangement functioned properly. Systemic Changes The Maintenance Director, or designee, will continue to perform documented monthly inspections of all egress doors with a delayed egress locking arrangement to ensure the correct signage is in place, and to ensure the doors properly function, on an ongoing basis as part of the facility's life safety program. Quality Assurance Results of the monthly egress door 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.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		3/6/25

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K 324	<p>Continued From page 4</p> <p>* 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</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their commercial cooking facility, in accordance with NFPA 101, for 1 of 1 sampled commercial cooking hood suppression systems.</p> <p>The findings included:</p> <p>On 02/04/2025, at 11:09 AM, during the fire safety tour of the facility with Maintenance Director, the Kitchen commercial cooking hood suppression system's seams were not sealed or otherwise made greashtight.</p> <p>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 02/04/2025 at</p>	K 324	<p>K324</p> <p>Corrective Actions</p> <p>The facility's kitchen hood seams were sealed to ensure that the kitchen hood was grease tight on 2/5/2025.</p> <p>Identification of Others Potentially Affected</p> <p>The facility only has one kitchen hood, so no further evaluations are needed.</p> <p>Systemic Changes</p> <p>The Maintenance Director, or designee, will continue to perform documented monthly inspections of the facility's kitchen hood to ensure the kitchen hood seams remain sealed and grease tight on</p>	

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K 324	Continued From page 5 2:40 PM. NFPA 96 (2011 Edition) 5.1.4, 10.2.6 NFPA 101 (2012 Edition) 2.1, 4.5.8, 4.6.12.1, 9.2.3, 19.3.2.5.1	K 324	an ongoing basis as part of the facility's life safety program. Quality Assurance Results of the monthly kitchen hood 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.	
K 372 SS=D	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 7 sampled compartments. The findings included:	K 372	Corrective Actions The following locations had penetrations sealed with fire stopping on 2/5/2025. A. 100 Hallway smoke barrier.	3/6/25

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K 372	<p>Continued From page 6</p> <p>On 02/04/2025, at the following times, during record review and the fire safety tour of the facility with the Regional Maintenance Director and the Maintenance Director, the following was observed:</p> <ol style="list-style-type: none"> At 11:58 AM, the 100 Hallway had one penetration through both sides of the 1-hour smoke wall, above the ceiling of the double fire rated doors. At 12:10 PM, the 300 Hallway had one penetration through both sides of the 1-hour smoke wall, above the ceiling of the double smoke doors. <p>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 02/04/2025 at 2:40 PM.</p> <p>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</p>	K 372	<p>B. 300 Hallway smoke barrier.</p> <p>Identification of Others Potentially Affected</p> <p>The Maintenance Director, or designee, performed a facility-wide assessment of the other fire and smoke barriers to ensure all penetrations are sealed with fire stopping.</p> <p>Systemic Changes</p> <p>The Maintenance Director, or designee, will perform monthly inspections X 3 months of the fire and smoke barriers to ensure all penetrations are sealed with fire stopping. Inspections will continue semi-annually thereafter on an ongoing basis as part of the facility's life safety program.</p> <p>Quality Assurance</p> <p>Results of the monthly fire and smoke barrier inspections will be presented at the monthly QA meetings X 3 months. If substantial compliance is not met after 3 months, monthly inspections will continue, and results will be brought to QA meetings until substantial compliance is met.</p>	

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K 372	Continued From page 7 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	K 372		
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 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 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	K 918		3/6/25

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K 918	<p>Continued From page 8</p> <p>the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to maintain and test their Essential Electrical System, in accordance with NFPA 99, for 2 of 2 generator batteries.</p> <p>The findings included:</p> <p>On 02/04/2025 between 10:00 AM and 1:30 PM, during record review with the Regional Director of Maintenance, the following was identified:</p> <ol style="list-style-type: none"> No documentation was provided for weekly voltage checks for 2 of 2 generator batteries. No documentation was provided for monthly sealed battery conductance tests for 2 of 2 generator batteries. <p>An interview was conducted with the Regional Director of Maintenance concurrent with the record review and he acknowledged the findings.</p> <p>NFPA 99 (2012 Edition) 6.4.1.1.13 NFPA 110 (2010 Edition) 8.3, 8.3.7, 8.3.7.1</p>	K 918	<p>K918</p> <p>Corrective Actions</p> <p>The following actions occurred on 2/17/2025.</p> <p>A. The weekly generator inspection form was updated to include a battery voltage reading for both generator batteries.</p> <p>B. The monthly generator inspection form was updated to include a battery conductance reading for both generator batteries.</p> <p>Identification of Others Potentially Affected</p> <p>Both facility generator batteries were accounted for, so no further evaluation was needed.</p> <p>Systemic Changes</p> <p>The Maintenance Director, or designee, will continue to perform documented weekly generator inspections to include documentation of the battery voltage, and monthly generator testing to include documentation of the battery conductance testing, on an ongoing basis as part of the</p>	

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K 918	Continued From page 9	K 918	<p>facility's life safety program.</p> <p>Quality Assurance</p> <p>Results of the weekly inspections and monthly battery testing will be presented at the monthly QA meetings X 3 months. If substantial compliance is not met after 3 months, monthly inspections will continue, and results will be brought to QA meetings until substantial compliance is met.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105852	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER BOCA CIRCLE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7225 BOCA DEL MAR DRIVE BOCA RATON, FL 33433		
(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	<p>Initial Comments</p> <p>During the Fire & Life Safety Recertification survey conducted on 02/04/2025 at Boca Circle Rehabilitation Center, a nursing home, Emergency Preparedness was reviewed.</p> <p>Boca Circle Rehabilitation Center is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

02/26/2025

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.