An unannounced complaint survey for CCR#2017010920 was conducted from September 13, 2017 through September 22, 2017 at Rehabilitation Center at Hollywood Hills, LLC. Rehabilitation Center at Hollywood Hills, LLC was not in compliance with State Licensure requirements for Nursing Homes at the time of the survey.

Class I violations which presented imminent danger to the residents were identified at:
- N110 - Physical Environment - Safe, Clean, Homelike
- N201 - Right to Adequate and Appropriate Health Care
- N216 - Health and Safety of Residents

A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility’s noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction.

The nursing home’s central air conditioning system became inoperable from the afternoon of September 10, 2017 through the early morning of September 13, 2017, after Hurricane Irma occurred. The facility residents were exposed to increasingly excessive heat, which caused 8 vulnerable residents to have severe heat-related conditions. These 8 residents consequently died on September 13, 2017. Six of 8 residents died from 4:30 AM to 7:54 AM on September 13,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

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

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<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(XS) COMPLETE DATE</th>
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<td>N 000</td>
<td>Continued From page 1</td>
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<td>2017. The other facility residents were evacuated to the hospital across the street to protect them from potential serious harm. At the initial time of the survey, the census was 141 residents.</td>
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<td>N 110</td>
<td>SS=K</td>
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<td></td>
<td><strong>400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike</strong></td>
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</tbody>
</table>
| | | | | | | 400.141(1)(h) FS  
Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. |
| | | | | | | 59A-4.122(1) FAC  
The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible |
| | | | | | | This Statute or Rule is not met as evidenced by:  
Based on interview and record review, the facility failed to provide a safe and comfortable environment for 8 of 8 sampled residents,  
Resident #1, #2, #3, #4, #5, #6, #7 and #8 out of 59 residents residing on the second floor of the facility. The facility failed to recognize the potential health risk of the rising internal facility temperatures and humidity, affecting vulnerable elderly residents residing in a facility that experienced a power outage related to Hurricane Irma, a major hurricane. The power outage resulted in the lack of adequate central air conditioning (AC), which exposed the facility residents to increasingly excessive heat. Eight vulnerable residents in the facility developed severe heat-related conditions and consequently died within 6 to 7 hours during the early morning of September 13, 2017. The other facility residents were evacuated to the hospital across |
The facility's failure to provide the necessary actions to maintain a safe and comfortable environment resulted in a situation that caused or had likely caused serious injury, harm, impairment, or death to the facility residents and required immediate corrective action. Cross refer to N201 and N215.

The findings included:

1. Review of the facility 2017 Comprehensive Emergency Management Plan, approved by the Broward County emergency management division on July 21/17, revealed the facility had contractual agreements with another long-term care facility and transportation company for emergency or evacuation purposes. These services were not activated after a major hurricane rendering the facility without air conditioning for approximately 62 hours or approximately 3 days. Additionally, the nursing home is located directly across the street from a large 621 bed local hospital, which did not lose power or air conditioning during or after the hurricane. According to Google Maps, the facility is located 0.2 miles (1056 feet) from the front door of the facility to the front door of the local hospital.

2. On 09/13/17 at approximately 12:30 PM, an interview was conducted with the facility Director of Engineering who stated at approximately 3:49 PM on 09/10/17 he heard a bang outside and determined a transformer located on a pole across the street had been hit by a tree. He stated at that time he began checking the AC function within various parts of the building. He stated the inside temperature was up to 77
Continued From page 3

degrees F due to the AC chiller not functioning as a result of the blown transformer. He further stated the malfunctioning line was the dedicated electric line to the facility AC chiller. Additionally he stated the facility has a functioning generator however, it is not hooked up to the central AC unit. He further stated on site they had 10 rented portable AC units and fans and he started to set them up immediately when he determined the central AC malfunctioned and they started to set up 2 in the adjoined behavioral hospital, and in the nursing home they set up 3 on the second floor and 4 on the first floor with one malfunctioning. Additionally he stated he placed fans in each resident room and large industrial fans set up in the hallways.

On 09/25/17 at 4:06 PM, a telephone interview was conducted with a state agency fire protection specialist who reviewed his facility file and determined the approximate square footage on the second floor was 16,000 square feet with 8-9 foot ceilings.

3. Review of the Weather Underground.com website temperature readings from the weather station at the Fort Lauderdale/Hollywood International Airport, located 6 land miles from the facility, indicated for 09/11/17 at 6:53 PM the outside temperature was 89.6 degrees Fahrenheit (F) with a heat index of 96.2 F and humidity of 55%.

On 09/11/17 at 11:55 PM, the outside temperature was 80.6 degrees F with a heat index of 86.2 and humidity of 84%.

On 09/12/17 at 7:53 AM, the outside temperature was 78.8 degrees F with a humidity of 89%.
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER’S PLAN OF CORRECTION</th>
<th>(X5) COMPLETE DATE</th>
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<td>N 110</td>
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On 09/12/17 at 12:53 PM, the outside temperature was 87.8 degrees F with a heat index of 95.6 degrees F and humidity of 62%.

On 09/12/17 at 6:53 PM, the outside temperature was 87.8 degrees F with a heat index of 92.6 degrees F and humidity of 55%.

On 09/12/17 at 10:53 PM, the outside temperature was 82.9 degrees F with a heat index of 91.8 degrees F and humidity of 82%.

On 09/13/17 at 1:53 AM, the outside temperature was 82 degrees F with a heat index of 89.4 degrees F with humidity of 82%.

On 09/13/17 at 4:53 AM, the outside temperature was 79 degrees F with 88% humidity.

4. On 09/13/17 at approximately 12:32 PM, an interview was conducted with the RN night shift Nurse Manager who stated he arrived on duty on 09/12/17 at 7:00 PM and noted portable AC coolers along with numerous fans located throughout the facility.

On 09/13/17 at 1:20 PM, an interview was conducted with the facility Administrator and Director of Nurses (DON). The Administrator stated he was onsite from Friday 09/08/17 around 1:30 PM to 2:00 PM and never left the facility until Monday 09/11/17 around 7:00 PM to 7:30 PM. He stated he had been active on the daily FL Health STAT Database and he had notified the state agency he would not be accepting any new residents due to the AC issues. He stated he left the facility last night (09/12/17) at around 11:00 PM - 11:30 PM and he received no report of resident concerns upon exiting. The DON stated during the interview on 09/13/17 at approximately...
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
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</table>
| N 110         | Continued From page 5 1:30 PM she remained in the facility on 09/08/17 through 09/11/17 leaving the facility around 1:30 PM. She stated she had instructed the nurses and aides to monitor the residents frequently and offer water and ice every hour. On 09/13/17 at approximately 12:32 PM the Registered Nurse (RN) night shift Nurse Manager stated on the 09/13/17 night shift commencing on 7:00 PM, he instructed the 4-5 licensed nurses on duty to monitor residents and provide ice water every hour. 5. a) Resident #1 was transferred by Emergency Medical Services (EMS) to the hospital on 09/13/17 at 3:24 AM with altered mental status. temperature as recorded in the Emergency Department (ED) was 107 degrees F. sustained cardiac and respiratory arrest. Resident #1 expired in the hospital ED on 09/13/17 at 3:09 PM. The final diagnosis was Heat Stroke. The Merriam-Webster Medline Plus Medical Dictionary definition of "heat stroke" is "a life-threatening condition characterized by cessation of sweating with inadequate elimination of body heat, extremely high temperature, rapid pulse, hot dry skin, flaccid muscles, delirium, collapse, and coma and resulting from prolonged exposure to high environmental temperature which causes a dysfunction of the temperature-regulating mechanism of the body". Review of the ED RN Triage note dated 09/13/17 at 3:29 AM documents, 'Rescue call for code, patient found non-verbal, with tympanic (taken in the ear) temp 107. Per rescue facility does not have AC.' On 09/13/17 at 7:53 AM an ED physician progress note documented under Assessment/Plan - "Hyperthermia of 107 degrees...
N 110 Continued From page 6

Fahrenheit; presumed non-exertional heatstroke since her nursing home has been without power since hurricane. Patient received IV fluid and cold water baths and fanning. Temp dropped to 41 C after the treatment and is now 37.8 C.'

b) Resident #2 was transferred by EMS to the hospital on 09/13/17 at 4:32 AM with cardiac and respiratory arrest. Temperature as recorded in the ED was 108.3 degrees F. Further review of the ED clinical record revealed documentation dated 09/13/17 at 4:33 AM completed by the ED RN stating 'Resident from (name of nursing home). Nursing staff called 911 for complaints of fever. On arrival patient noted to be in cardiac arrest with CPR (cardiopulmonary resuscitation) in progress. EMS states conditions of facility were untenable due to lack of functioning AC. EMS states they did note fans however they were inadequate in relationship to patient's location whereabouts.' Resident #2 expired in the hospital ED on 09/13/17 at 5:00 AM.

c) Resident #3 was admitted to the facility on 06/30/16 and subsequently admitted to hospice services on 10/16/16. Review of the clinical record revealed the last documented physician hospice note in the chart dated 08/01/17 documents 'Resident with history of end stage heart failure, history of hypertension, weakness, and aspiration.' Review of the hospice records dated 09/06/17 documents the resident was exhibiting agitation requiring medications. There is no further documentation regarding the resident's status up to 09/12/17, 2 days after the hurricane, when was assessed by the physician to be experiencing multi system decline including respiratory distress. The resident was subsequently placed on 24-hour hospice bedside nursing care for comfort measures. Review of the
N 110 Continued From page 7

facility Vital Signs record revealed the last documented temperature is 97 degrees F dated 09/12/17 at 12:00 AM.

Review of the hospice Continuous Care Shift Care Note dated 09/12/17 at 8:00 PM documents the resident's temperature is 99.5 degrees F with a respiratory rate of 36. Further review of the note documents at 9:00 PM the resident's temperature is 102.5 degrees F. Resident #3 was administered Tylenol at 9:00 PM on 09/12/17. On 09/12/17 at 10:00 PM, Resident #3's temperature was 102 degrees F with a heart rate of 115 and respiratory rate of 42. Review of the Continuous Care Shift Care Note the hospice Licensed Practical Nurse documented at 10:00 PM 'SOB (shortness of breath), head of bed up to facilitate ease of breathing; cool room with fan to facilitate of the air circulation of the room maintained.'

Resident #3 expired on 9/13/17 at 1:35 AM with the hospice nurse at bedside.

d) Resident #4 was found in his room on 09/13/17 at approximately 4:30 AM in cardiac arrest. 911 was called. EMS pronounced the resident expired in the facility.

e) Resident #5 was discovered deceased in his room on 09/13/17 at approximately 4:30 AM. He was pronounced deceased by EMS while they were on site.

f) Resident #6 was discovered in his room unresponsive and not breathing on 09/13/17 at approximately 4:30 AM. EMS personnel were on site and initiated CPR. CPR was not successful and EMS pronounced Resident #6 deceased.

g) Resident #7's was transferred by EMS to the hospital on 09/13/17 at 7:03 AM with cardiac and respiratory distress. temperature as recorded
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<th>N 110</th>
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<tr>
<td></td>
<td>in the ED at 7:50 AM was 108.5 degrees F.</td>
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<td>Review of resident #7’s ED clinical record</td>
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<td>revealed documentation by the ED RN dated</td>
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<td>09/13/17 at 7:05 AM stating 'Received patient</td>
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<td>from a nursing facility for fever and unresponsive.</td>
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<td>Per EMS nursing facility has no air conditioning</td>
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<td>and patient possible has heat exhaustion. Patient</td>
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<td>arrived on a non-rebreather with labored shallow</td>
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<td>respirations. Cardiac monitor applied. Patient is</td>
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<td>pulseless, CPR initiated.'</td>
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<tr>
<td></td>
<td>Review of the ED clinical record revealed</td>
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<td>documentation by the ED physician dated</td>
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<td>09/13/17 at 7:10 AM states, 'Patient with history</td>
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<td>of hypertension presents to the ED with SOB</td>
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<td>onset PTA (prior to arrival). Patient was brought in</td>
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<td>by EMS from (name of facility). They have not</td>
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<td>had electricity since Monday due to the hurricane.</td>
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<td>was brought in with SOB and became</td>
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<td>unresponsive with asystole (flat line cardiac</td>
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<td>rhythm) on arrival. Resident #7 expired in the</td>
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<td>hospital ED on 09/13/17 at 7:54 AM.</td>
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<td>h) Resident #8 was transferred by EMS to the</td>
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<td>hospital on 09/13/17 at 6:42 AM with cardiac</td>
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<td>arrest and severe hyperthermia. Resident #8 was</td>
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<td>pronounced deceased at 6:49 AM.</td>
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<td>temperature recorded in the ED at 7:04 AM,</td>
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<td>following death, was 108.9 degrees F.</td>
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<tr>
<th>N 201</th>
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<tr>
<td></td>
<td>400.022(1)(l), FS Right to Adequate and</td>
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<td>Appropriate Health Care</td>
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<tr>
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<td>The right to receive adequate and appropriate</td>
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<td>health care and protective and support services,</td>
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<td>including social services; mental health services,</td>
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## Statement of Deficiencies and Plan of Correction

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<th>ID</th>
<th>Prefix</th>
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<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>Complete Date</th>
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<td>N 201</td>
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If available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

This Statute or Rule is not met as evidenced by:

Based on interview and record review, the facility failed to ensure the rights of 8 of 8 medically fragile residents, out of a total of 59 residents residing on the second floor, to receive adequate and appropriate health care. These 8 residents were Residents #1, #2, #3, #4, #5, #6, #7, and #8.

The facility's central air conditioning system became inoperable from the afternoon of September 10, 2017 through the early morning of September 13, 2017, after Hurricane Irma occurred. The facility residents were exposed to increasingly excessive heat, which caused the 8 affected residents to have serious heat-related conditions and these residents consequently died. The other facility residents were evacuated to the hospital across the street to protect them from potential serious harm. The facility's failure to provide the adequate and appropriate health care resulted in a situation that caused or had likely caused serious injury, harm, impairment, or death to the facility residents and required immediate corrective action.

Cross refer to N110 and N216

The findings included:

1. On 09/13/17 at approximately 12:30 PM, an interview was conducted with the facility Director of Engineering who stated at approximately 3:49 PM on 09/10/17 he heard a bang outside and determined a transformer located on a pole...
<table>
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<th>(X4) ID PREFIX TAG</th>
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<td>N 201</td>
<td>Across the street had been hit by a tree. He stated at that time he began checking the AC (air conditioner) function within various parts of the building. He stated the inside temperature was up to 77 degrees due to the AC chiller not functioning as a result of the blown transformer. He further stated the malfunctioning line was the dedicated electric line to the facility AC chiller. Additionally he stated the facility never lost power during the storm and as a result, the generator was not needed.</td>
<td>N 201</td>
<td>Review of medical records available for Resident #1 on 09/15/17 indicated Resident #1 was admitted to the facility on 09/28/15 with medical diagnoses including Chronic Obstructive Pulmonary Disease (COPD), heart failure, hypertension, atrial fibrillation, diabetes and dyspnea (difficulty breathing). Review of the Federally required comprehensive resident assessment, referred to as the MDS (Minimum Data Set) quarterly assessment with an Assessment Reference Date (ARD) of 04/07/17 documents under Cognitive Pattern the resident scored a 15 out of 15 on the BIMS (brief interview of mental status) scale and Functional Status is documented as extensive assistance for mobility and ADLs (activities of daily living). Further review of the medical record indicated that Resident #1’s vital signs were being monitored. Review of the September 2017 Medication Administration Record (MAR), 'last entry' dated 09/11/17 at 11:53 PM indicated Temperature (T) 97, Heart Rate (HR) 80, Respiratory Rate (RR) 19 and Blood Pressure (BP) 130/72 mmHg at 6:37AM. Reference ranges for a normal adult vital signs obtained from the National Institute of Health/U.S.</td>
<td>09/22/2017</td>
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National Library of Medicine are as follows:
Temperature 97.8 to 99.1 F; Heart Rate 60-100 beats per minute; Respiratory Rate 12-18 breaths per minute; Blood Pressure 90/60 to 120/80 millimeter of mercury.

The September 2017 MAR indicated that the resident was prescribed and receiving oxygen 2 Liters per minute continuously via nasal cannula and ordered fluid restrictions for a total of 900 ml (milliliters) every shift, 600 ml dietary/ 300 ml nursing.

Review of the available facility nursing progress note dated on 09/14/17 at 7:43 PM, indicated as a 'late entry' by a Registered Nurse (RN) that she reported to duty at 7 PM and observed Resident #1 sitting up in bed in the hallway by the nurses station and had oxygen being administered continuously. The note indicated the resident was in stable condition, with no signs of respiratory distress, was afebrile (no fever) and respirations were even and unlabored. The nurse documented that the resident's vital signs were stable and fluids were offered and tolerated well.

Review of available nursing progress note dated 09/13/17 at 5:01 AM by the RN night shift Nurse Manager indicated that Resident #1 was observed to be in respiratory distress. The resident's vital signs indicated BP 128/68, and 80% oxygen saturation rate on room air with 15 liters via non-breather, which improved to 92% oxygen saturation. 911 was called and the resident was transferred via Emergency Medical Services (EMS) to the hospital for evaluation. According to MayoClinic.org website, normal pulse oximeter readings for oxygen saturation rates usually range from 95 to 100 percent. Values under 90 percent are considered low.

N 201 Continued From page 11
In an interview with the RN night shift Nurse Manager on 09/13/2017 starting at 12:32 PM, he stated he began his shift on 09/12/17 at 7 PM and had received report that "all residents were stable and everything was under control." He stated that he had instructed the nurses on duty to monitor all the residents and provide ice water every 1 hour. He recalled around 1:30 AM, he was called to resident #1's room, where Resident #1 was observed in respiratory distress. He stated the resident's lips were bluish in color and after he assessed did not require CPR (cardiopulmonary resuscitation). He stated that he applied additional oxygen and the resident's vital signs were stable. He stated that 911 was called and Resident #1 was transferred by EMS to the hospital for evaluation. He stated that Resident #1 was alive and breathing on transfer.

Review of the hospital clinical record revealed Resident #1 arrived to the hospital Emergency Department (ED) via EMS on 09/13/17 at 3:24 AM with a chief complaint of altered mental status.

Review of the ED Registered Nurse (RN) Triage note dated 09/13/17 at 3:29 AM documents, "Rescue call for code, patient found non-verbal, with tympanic (taken in the ear) temp 107. Per rescue facility does not have AC (air conditioning)."

Review of the ED clinical record revealed initial vital signs documented on 09/13/17 at 3:30 AM by the ED RN to include a temperature of 40.7 degrees Celsius (C) (105.3 Fahrenheit (F) via axillary route (under arm pit). Resident #1's BP is documented as 100/57; HR 150; RR 27. Emergent treatment was commenced on arrival...
Further review of the ED clinical record revealed Resident #1 deteriorated rapidly and required emergent endotracheal tube intubation and mechanical ventilation for acute respiratory failure on 09/13/17 at 3:39 AM.

On 09/13/17 at 3:43 AM, Resident #1’s core temperature is documented as 41.7 degrees C. (107.1 F).

On 09/13/17 at 4:20 AM, Resident #1’s core temperature is documented as 41 degrees C. (105.8 degrees F).

Review of documentation by the ED RN dated 09/13/17 at 4:30 AM states Resident #1 ‘Received 5 liters of cold normal saline and ice packs were applied to underarms, groin and posterior neck and the temperature in the room was decreased to 55 degrees F.’

Further review of the ED clinical record dated 09/13/17 at 7:30 AM, revealed Resident #1’s BP was dropping necessitating the initiation of an intravenous Dopamine drip to sustain her blood pressure and subsequently intravenous Levophed, an additional medication to sustain blood pressure.

On 09/13/17 at 7:53 AM an ED physician progress note documented under Assessment/Plan - ‘Hyperthermia of 107 degrees Fahrenheit; presumed non-exertional heatstroke since her nursing home has been without power since hurricane. Patient received IV fluid and cold water baths and fanning. Temp dropped to 41 C after the treatment and is now 37.8 C.’
Continued From page 14

On 09/13/17 at 8:15 AM, the residents' health care surrogate made the decision to withdraw any further life support measures.

On 09/13/17 at 9:10 AM, an intravenous Morphine drip was commenced.

On 09/13/17 at 9:22 AM, the mechanical ventilation was discontinued and the oral endotracheal tube was removed.

On 09/13/17 at 3:09 PM Resident #1 was pronounced by the physician; patient pulseless with no respirations.

The Clinical Impression as documented in the clinical record by the ED physician after initial assessment on 09/13/17 at 3:34 AM, states under Diagnosis, 'Heat stroke.' The Merriam-Webster Medline Plus Medical Dictionary definition "heat stroke" is "a life-threatening condition characterized by cessation of sweating with inadequate elimination of body heat, extremely high temperature, rapid pulse, hot dry skin, flaccid muscles, delirium, collapse, and coma and resulting from prolonged exposure to high environmental temperature which causes a dysfunction of the temperature-regulating mechanism of the body".

3. Review of medical records available for Resident #2 on 09/15/17 indicated the resident was admitted to the facility on 06/26/17 with medical diagnoses including peripheral vascular disease (PVD), history of transient ischemic attack (TIA), cough, dementia, dysphagia (difficulty swallowing), history of pneumonia status post aspiration, and percutaneous endoscopic gastrostomy (PEG) placement for nutritional and hydration needs.
### Statement of Deficiencies and Plan of Correction

**State:**

**Agency:**

**State:**

**Rehabilitation Center at Hollywood Hills, L**

**Address:** 1200 N 35th Ave, Hollywood, FL 33021

### Summary Statement of Deficiencies

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<tr>
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Review of the quarterly MDS with an ARD of 05/04/17 documents the resident has severe cognitive impairment and was totally dependent for her mobility and ADLs.

Further review of the record indicated that on 09/12/17 at 7:11 PM, Resident #2 was assessed with no respiratory distress, but had an axillary (under armpit) temperature of 99.8 degrees F. The RN notified the health care provider and administered Tylenol 325 milligrams via the PEG tube. A follow-up temperature indicated a decrease in temperature to 98.8 degrees F. Further review of the record indicated no additional temperature monitoring conducted.

Review of the progress note dated on 09/13/17 at 4:42 AM indicated the RN observed Resident #2 to have shortness of breath (SOB) and positive breath sounds for rhonchi. The note indicated the RN suctioned the resident twice and vital signs were taken, BP 126/78, HR 104, RR 24, labored, and T 101.6 degrees F. The resident was assessed to have 77% oxygen saturation on room air and oxygen was applied. 911 was called and Resident #2 was transferred by EMS to the hospital for evaluation.

In an interview with the RN night shift Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that earlier in the evening, he had observed Resident #2 in the 2nd floor hallway, near a portable air conditioner (AC) cooler. He stated that at approximately 2:30AM on 09/13/2017, he was called by staff to the Resident #2's room, observed in respiratory distress, and foaming at the mouth. He stated that he suctioned the resident's mouth and told a staff to call 911 for EMS transfer to the hospital for evaluation.
Review of the hospital clinical record revealed Resident #2 arrived to the hospital ED via EMS on 09/13/17 at 4:32 AM with a chief complaint of cardiac arrest.

Review of the ED clinical record dated 09/13/17 at 4:34 AM completed by the ED physician documents 'Patient presents to ED via EMS from nursing home as a code heart today. Per EMS the patient was found to have a temp of 107 on scene.'

Review of the hospital Vital Signs log documents the initial temperature taken on 09/13/17 at 4:33 AM was 42.4 °C (108.3 °F.). Resident #2 did not have a recordable pulse or blood pressure.

Further review of the ED clinical record revealed documentation dated 09/13/17 at 4:33 AM completed by the ED RN stating 'Resident from (name of nursing home). Nursing staff called 911 for complaints of fever. On arrival patient noted to be in cardiac arrest with CPR in progress. EMS states conditions of facility were untenable due to lack of functioning AC. EMS states they did note fans however they were inadequate in relationship to patient's location whereabouts.'

Review of the ED Course documentation by the ED physician dated 09/13/17 commencing at 4:34 AM and continuing to 5:00 AM, documents 'Per rescue patient was hyperthermic (an increased temperature in the body), (confirmed in the ED) with asystolic (flat line heart rhythm) arrest. ACLS (advanced cardiac life support) initiated in the field and continued in the ED. No sustained rhythm despite ACLS. Patient pronounced.'

Despite resuscitative efforts in the ED, Resident...
Continued From page 17

4. Resident #3 was admitted to the facility on 06/30/16 and subsequently admitted to hospice services on 10/16/16. Review of the clinical record revealed the last documented physician hospice note in the chart dated 08/01/17 documents 'Resident with history of end stage heart failure, history of hypertension, weakness, and aspiration.' Review of the hospice records dated 09/06/17 documents the resident was exhibiting agitation requiring medications. There is no further documentation regarding the resident’s status up to 09/12/17, 2 days after the hurricane, when was assessed by the physician to be experiencing multi system decline including respiratory distress. The resident was subsequently placed on 24-hour hospice bedside nursing care for comfort measures. Review of the facility Vital Signs record revealed the last documented temperature is 97 degrees F dated 09/12/17 at 12:00 AM.

Review of the hospice Continuous Care Shift Care Note dated 09/12/17 at 8:00 PM documents the resident’s temperature is 99.5 degrees F with a respiratory rate of 36. Further review of the note documents at 9:00 PM the resident’s temperature is 102.5 degrees F. Resident #3 was administered Tylenol at 9:00 PM on 09/12/17. On 09/12/17 at 10:00 PM, Resident #3's temperature was 102 degrees F with a heart rate of 115 and respiratory rate of 42. Review of the Continuous Care Shift Care Note the hospice Licensed Practical Nurse documented at 10:00 PM 'SOB (shortness of breath), head of bed up to facilitate ease of breathing; cool room with fan to facilitate of the air circulation of the room maintained.' Resident #3 expired on 9/13/17 at 1:35 AM with the hospice nurse at bedside.
5. Resident #4 was admitted to the nursing home on 10/17/15 with diagnoses to include dementia, hypertension, congestive heart failure, peripheral vascular disease, right above knee amputation, anemia, and atherosclerotic heart disease. Resident #4 had 'Full Code' cardiac resuscitation directives.

Review of the quarterly MDS with an ARD of 04/19/17 documents the resident scored a 6 out of 15 on the BIMS, indicating severe cognitive impairment with functional status requiring extensive assistance for mobility and ADLs.

Review of the facility Vital Signs record dated 09/13/17 at 1:28 AM documents the resident's T at 97 degrees F; HR of 74 and RR of 18, and at 1:29 AM, the resident's blood pressure is documented as 128/74. There are no further vital signs or temperatures documented in the clinical record reviewed.

Review of Resident #4’s clinical record revealed a Nursing Progress Note dated 09/14/17 at 7:42 PM the Licensed Practical Nurse (LPN) documented, 'Late entry: Patient received at 11:15 PM (no date documented) resting in bed, no distress noted. Respiration even and non-labored. Blood pressure within normal limits, afebrile. Remain in stable condition.'

The next entry in the Nursing Progress Notes dated 09/14/17 at 7:54 PM by the LPN documented, 'Late entry: approximately 4:00 AM patient noted cardiac arrest with shallow breathing. BP 90/56, RR 15, HR 52. Non-rebreather applied, heart rate ceased. CPR initiated. 911 called. Rescue arrived pronounced resident death.'
Further review of Resident #4’s clinical record revealed no evidence of documentation when EMS arrived; no documentation of the time the EMS pronounced the resident's death; no documentation the resident's physician or family were notified of death.

In an interview with the RN night Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that at approximately 4:30AM, he was called to Resident #4’s room, where Resident #4 was found unresponsive and he immediately began to perform CPR since the resident had full code resuscitation status. The RN night Nurse Manager stated that he instructed a staff member to call 911 and when the EMS arrived, they evaluated Resident #4 and instructed him to stop performing CPR. He stated that while EMS was on site in Resident #4’s room, a roommate, Resident #5 was observed by staff, not to be breathing. The RN night Nurse Manager stated that CPR was not initiated, due to Resident #5's "Do Not Resuscitate" (DNR) directive.

6. Review of medical records available for Resident #5 on 09/15/17 indicated the resident was admitted to the facility on 05/09/03 with medical diagnoses including cardiac disease, hypertension, history of head injury, TIA (Transient Ischemic Attacks), cellulitis of the abdominal wall, PEG placement, dementia, dysphagia, chronic pain, multiple contracture sites, incontinence of bowel and bladder, aphasia (inability to verbally express oneself) and impaired mobility.

Review of a significant change MDS with an ARD of 05/12/17 documented the resident has severe cognitive impairment and was totally dependent
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING:** ______________________

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

100611

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**B. WING _____________________________**

**DATE SURVEY COMPLETED:**

09/22/2017

**NAME OF PROVIDER OR SUPPLIER**

REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1200 N 35TH AVE

HOLLYWOOD, FL 33021

**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)

**COMPLETE DATE**

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**N 201** Continued From page 20

for mobility and ADLs.

Review of Resident #5’s vital signs monitoring indicated on 09/12/17 at 2:20 PM- T 98.6, RR 16, HR 76, and BP 126/72.

Review of available medical record progress notes dated on 09/14/17 at 8:15 as a late entry"-indicated Resident #5 was observed at 11:15 (the time documented did not indicate AM or PM) to be resting in bed with respirations that were even and unlabored. No additional documentation was available for review. As indicated above, Resident #5 was evaluated by EMS after attending to Resident #4 and pronounced dead by EMS while on site according to the interview conducted on 09/13/17 at 12:32 PM with the RN night Nurse Manager.

7. Review of medical records available for Resident #6 on 09/15/17 indicated that the resident was admitted to the facility on 02/09/17 with medical diagnoses including hypertension, COPD with exacerbation, bronchitis, asthma, benign prostatic hyperplasia (BPH), history of falls, generalized weakness, functional decline, history of urinary tract infection (UTI), incontinence of bowel and bladder and pressure wounds.

Review of the quarterly MDS with an ARD 08/16/17 documented the resident scored a 15 out of 15 on the BIMS indicating no cognitive impairment with functional status requiring extensive assistance for mobility and ADLs.

Review of the September 2017 MAR indicated the last documentation on 09/13/17 at 1:42 AM- T 97, HR 69, RR18, and BP 120/76. Review of progress notes indicated the last entry, dated on
Continued From page 21

09/04/17, which revealed the resident refused shower and was given a bed bath instead.

In an interview with the RN night Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that at approximately 4:30 AM, staff notified him that Resident #6, was found to be unresponsive and not breathing. He stated that EMS personnel were already in the facility, and initiated CPR, due to the resident's full code directive status and EMS personnel pronounced the resident death. The nurse stated that the resident had not exhibited any signs of distress prior to death.

8. Review of medical records available for Resident #7 on 09/15/17 indicated that the resident was admitted to the facility on 09/12/15 with medical diagnoses including cerebral infarction with cerebrovascular accident (CVA), aphasia, hypertension, cardiovascular disease, generalized muscle weakness, history of UTI, protein malnutrition, dysphagia and PEG tube placement.

Review of the quarterly MDS with an ARD of 06/18/17 documented the resident has severe cognitive impairment and was totally dependent for mobility and ADLs.

Record review indicated the last vital signs taken on 09/12/17 at 10:34 PM, were documented as T 97, HR 70, RR 16 and BP 122/74. The last nursing note entry was dated on 08/09/17 at 10:53 PM, which indicated the resident was stable.

Review of the hospital clinical record revealed Resident #7 arrived to the hospital ED via EMS on 09/13/17 at 7:03 AM with a chief complaint of...
shortness of breath.

Review of the EMS Initial Patient Assessment form dated 09/13/17 documented their patient contact at the facility was at 6:55 AM. The narrative of events included altered mental status, hyperthermia and respiratory distress. The patient's temperature is documented as 103.3 degrees F and skin temperature as feeling hot.

Review of the ED clinical record revealed documentation by the ED RN dated 09/13/17 at 7:05 AM stating, "Received patient from a nursing facility for fever and unresponsive. Per EMS nursing facility has no air conditioning and patient possible has heat exhaustion. Patient arrived on a non-rebreather with labored shallow respirations. Cardiac monitor applied. Patient is pulseless, CPR initiated."

Review of the ED clinical record revealed documentation by the ED physician dated 09/13/17 at 7:10 AM states, "Patient with history of hypertension presents to the ED with SOB (shortness of breath) onset PTA (prior to arrival). Patient was brought in by EMS from (name of facility). They have not had electricity since Monday due to the hurricane. was brought in with SOB and became unresponsive with asystole on arrival.

Resuscitative efforts were commenced in the ED.

Resident #7's temperature on 09/13/17 at 7:50 AM is documented in the ED record as 42.5 degrees C rectally (108.5 degrees F).

Despite resuscitative efforts, Resident #7 expired at 7:54 AM in the ED.
N 201 Continued From page 23

9. Review of medical records available for Resident #8 on 09/15/17 indicated that the resident was admitted to the facility on 11/17/09 with medical diagnoses including heart disease, hypertension, CVA, hemiplegia (paralysis to one side of the body), convulsions, and atrial fibrillation.

Review of the quarterly MDS with an ARD of 08/15/17 documents a BIMS score of 14 out of 15, which indicated the resident was cognitively intact and was totally dependent for mobility and ADLs.

Further review of the record indicated the vital signs on 09/12/17 at 4:16 AM, the resident had a temperature of 102 degrees F and Tylenol 650 mg was administered as ordered. Follow-up vital sign monitoring on 09/12/17 at 2:18 PM indicated - T 98.2, RR 16, HR 70, and BP 134/76.

Review of the progress note dated on 09/13/17 at 3:31 AM, written by the LPN, indicated that Resident #8 was observed to be alert with flushed, clammy skin. Vital sign monitoring revealed - BP 148/76, HR 79, RR 19, T101 F, with 88% oxygen saturation on room air. Oxygen at 2 liters via nasal cannula was administered to the resident with an increase to 96% oxygen saturation. Tylenol was administered as ordered for fever. Further review of the progress note, time stamped on "09/14/17 at 8:05 PM" indicated "late entry" the LPN documented stating at approximately 4:20 AM resident #8 had a change of condition and was observed in respiratory distress. The note further indicated the resident's respiratory rate was 28 breaths /minute, rapid and labored and oxygen was applied. 911 was called to transfer the resident by EMS to the hospital for evaluation.
Review of the hospital clinical record revealed Resident #8 arrived to the hospital ED via EMS on 09/13/17 at 6:42 AM with a chief complaint of cardiac arrest and severe hyperthermia.

Review of the ED record revealed Resident #8 was pronounced dead at 6:49 AM on 09/13/17.

Review of the ED Vital Signs documentation revealed Resident #8's temperature taken following death on 09/13/17 at 7:04 AM was 43.3 degrees C (109.9 F) rectally.

Review of the ED physician summary documentation dated 09/13/17 at 7:47 AM states in part, "patient who presents to Emergency Department with a chief complaint of cardiac arrest. Patient has a medical history of hypertension, hypothyroidism, seizure disorder, history of stroke is likely bed bound patient arriving from skilled nursing facility. Patient arrives extremely hyperthermic, in asystolic cardiac arrest ...pulse check was performed every 3-5 minutes. The patient continued to be in asystolic arrest bedside ultrasound shows no cardiac activity."

The ED physician further documented on 09/13/17 at 7:47 AM, "In summary, arriving from a skilled nursing facility in asystolic cardio arrest very hyperthermic, cold fluids were administered in the emergency department. Patient remained asystolic on the monitor. No cardiac activity was noted on any of the ultrasound checks. No obvious reversible cause to explain asystolic arrest. The patient was pronounced dead by me. Team was in agreement to call code. RN attempting to call family."
**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID PREFIX TAG</th>
<th>Provider’s Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Complete Date</th>
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<tbody>
<tr>
<td>N 201</td>
<td>Continued From page 25</td>
<td>N 201</td>
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<tr>
<td>N 216</td>
<td>400.102(1), FS Health and Safety of Resident</td>
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<td>In addition to the grounds listed in part II of chapter 408, any of the following conditions shall</td>
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<td>be grounds for action by the agency against a licensee:</td>
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<td>(1) An intentional or negligent act materially affecting the health or safety of residents of the</td>
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<td>facility.</td>
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<td>This Statute or Rule is not met as evidenced by:</td>
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<td>Based on interview and record review, the facility staff failed to ensure 8 of 8 vulnerable residents</td>
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<td>out of 59 residents residing on the second floor of the facility were free from neglect, (Residents</td>
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<td>#1, #2, #3, #4, #5, #6, #7 and #8). The facility's central air conditioning system became inoperable</td>
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<td>from the afternoon of September 10, 2017 through the early morning of September 13, 2017, after</td>
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<td>Hurricane Irma occurred. The facility residents were exposed to increasingly excessive heat, which</td>
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<td>caused the 8 affected residents to have serious heat-related conditions and these residents</td>
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<td>consequently died. The other facility residents were evacuated to the hospital across the street to</td>
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<td>protect them from potential serious harm. The facility's failure to provide the necessary goods</td>
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<td>and services to avoid residents' physical harm, pain, mental anguish, or emotional distress,</td>
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<td>resulted in immediate jeopardy. Cross refer to N110 and N201.</td>
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<td>The findings included:</td>
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<td>1. Review of the facility's 2017 Emergency</td>
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Management Plan, approved by the Broward County Emergency Management Division on July 21, 2017 revealed, the facility had contractual agreements with another long-term care facility and transportation company for emergency or evacuation purposes. These services were not activated after a major hurricane rendering the facility without air conditioning (AC) for approximately 62 hours or approximately 3 days. Additionally, the nursing home is located directly across the street from a large 621 bed local hospital, which did not lose power or AC during or after the hurricane. According to Google Maps, the facility is located 0.2 miles (1056 feet) from the front door of the facility to the front door of the local hospital.

On 09/13/17 at approximately 12:30 PM, an interview was conducted with the facility Director of Engineering who stated at approximately 3:49 PM on 09/10/17 he heard a bang outside and determined a transformer located on a pole across the street had been hit by a tree. He stated at that time he began checking the AC function within various parts of the building. He stated the inside temperature was up to 77 degrees Fahrenheit (F) due to the AC chiller not functioning as a result of the blown transformer. He further stated the malfunctioning line was the dedicated electric line to the facility AC chiller. Additionally he stated the facility never lost power during the storm and as a result, the generator was not needed. He confirmed the generator the facility had on site was not powerful enough to run the AC and the AC could not be connected to that generator. He further stated on site they had 10 rented portable AC units and fans and he started to set them up immediately when he determined the central AC malfunctioned. He stated he started to set up 2 in the adjoined
**N 216** Continued From page 27

behavioral hospital, and in the nursing home they set up 3 on the second floor and 4 on the first floor with one of the 10 units malfunctioning. Additionally he stated he placed fans in each resident room and large industrial fans set up in the hallways.

On 09/13/17 at 1:20 PM, an interview was conducted with the facility Administrator and Director of Nurses (DON). At the time of the interview on 09/13/17 at 1:20 PM, the power to the facility's AC unit had not been restored yet per the Administrator. The Administrator stated he was onsite from Friday 09/08/17 around 1:30 PM to 2:00 PM and never left the facility until Monday 09/11/17 around 7:00 PM to 7:30 PM. He stated he had been active on the daily Florida Health STAT Database reporting system and he had notified the state agency he would not be accepting any new residents due to the AC issues. He stated he left the facility last night (09/12/17) at around 11:00 PM - 11:30 PM and he received no report of resident concerns upon exiting. The DON stated, during the interview on 09/13/17 at approximately 1:30 PM she remained in the facility on 09/08/17 through 09/11/17 leaving the facility around 1:30 PM. She stated, she had instructed the nurses and aides to monitor the residents frequently and offer water and ice every hour.

On 09/25/17 at 4:06 PM, a telephone interview was conducted with a state agency fire protection specialist who reviewed his facility file and determined the approximate square footage on the second floor of the facility was 16,000 square feet with 8-9 foot ceilings. During the interview with the fire protection specialist, it could not be determined how many square feet each portable AC unit could effectively cool.
2. Review of Florida Governor, Rick Scott's released timeline dated September 19, 2017, the following was documented:

"On Sunday, September 10, 2017 at 6:46 PM, the (name of facility) was again notified by the state to report updates to the FL Health STAT Database on post-storm Hurricane Irma response. The facility was asked to provide updates to the database at least twice a day. However if significant changes occurred, they would have to report additional updates. All ALF's, nursing homes and hospitals were asked to comply. On Sunday, September 10, 2017 at 6:51 PM, the (name of nursing home) reported through the FL Health STAT Database that they were closed but that everything was operational, including heating and cooling."

"On Monday, September 11, 2017 at 7:30 AM, the (name of facility) previously provided update was counted as their current status in the FL Health STAT Database since they did not report any changes. Per this report, everything remained operational at the (name of facility)."

"On Monday, September 11, 2017 at 5:37 PM, the (name of facility) called the Florida Emergency Information Line, a toll-free hotline activated at the time of an emergency to provide an additional resource for those in Florida to receive accurate and up-to-date information. This line is an information only line for Floridians and is not meant to replace 911."

"On Tuesday, September 12, 2017 at 1:30 PM, the (name of facility) previously provided update was counted as their current status in the FL Health STAT Database since they did not report..."
Continued From page 29 any changes."

"On Tuesday, September 12, 2017 at 2:00 PM, as part of all impacted counties daily submissions, Broward County submitted a situation report to the state Division of Emergency Management that included an update on all health and medical aspects of storm response in Broward County. Included in this report was a note that the (name of facility) is running on generator power without air conditioning, which is adversely affecting patients, and that a ticket had been put into the power company to ensure priority status."

"On Tuesday, September 12, 2017 at 4:17 PM, a state representative returned the call left on the Governor's personal cell phone by contacting (facility Administrator). The Administrator reported that the (name of facility) was open, that the chiller was not operational pulling outside air but that they had spot coolers and fans, and that power was partial. The Administrator did not, at any time during the call, report or indicate that conditions had become dangerous or that the health and safety of their patients was at risk.

State representative advised Administrator to call 911 if there was any reason to believe that the health or safety of patients was at risk."

The timeline indicated the AC power went out on 09/10/17 at approximately 3:49 PM and as of 09/12/17 at 4:17 PM, the facility was still without functioning central air conditioning for approximately 47 consecutive hours. The Administrator did not report or indicate any conditions that had become dangerous or posed a risk to the residents and as of 09/13/17 at approximately 3:00 AM, per the time line, the first patient was taken emergently to the hospital from the facility in critical condition.
**3. Review of the Weather Underground.com website temperature readings from the weather station at the Fort Lauderdale/Hollywood International Airport, located 6 land miles from the facility, indicated for 09/11/17 at 5:53 PM the outside temperature was 89.6 degrees F with a heat index of 96.2 F and humidity of 55%.**

On 09/11/17 at 11:55 PM, the outside temperature was 80.6 degrees F with a heat index of 86.2 degrees and humidity of 84%.

On 09/12/17 at 7:53 AM, the outside temperature was 78.8 degrees F with a humidity of 89%.

On 09/12/17 at 12:53 PM, the outside temperature was 87.8 degrees F with a heat index of 95.6 degrees F and humidity of 62%.

On 09/12/17 at 6:53 PM, the outside temperature was 87.8 degrees F with a heat index of 92.6 degrees F and humidity of 55%.

On 09/12/17 at 10:53 PM, the outside temperature was 82.9 degrees F with a heat index of 91.8 degrees F and humidity of 82%.

On 09/13/17 at 1:53 AM, the outside temperature was 82 degrees F with a heat index of 89.4 degrees F with humidity of 82%.

On 09/13/17 at 4:53 AM, the outside temperature was 79 degrees F with 88% humidity.

**4. a) Review of medical records available for Resident #1 on 09/15/17 indicated Resident #1 was admitted to the facility on 09/28/15 with medical diagnoses including Chronic Obstructive Pulmonary Disease (COPD), heart failure,**
Continued From page 31

hypertension, atrial fibrillation, diabetes and dyspnea (difficulty breathing).

Review of the Federally required comprehensive resident assessment, referred to as the MDS (Minimum Data Set) quarterly assessment with an Assessment Reference date (ARD) of 04/07/17 documents under Cognitive Pattern the resident scored a 15 out of 15 on the BIMS (brief interview of mental status) scale and Functional Status is documented as extensive assistance from nursing staff for mobility and ADLs (activities of daily living).

Further review of the medical record indicated that Resident #1’s vital signs were being monitored. Review of the September 2017 Medication Administration Record (MAR), ‘last entry’ dated 09/11/17 at 11:53 PM indicated Temperature (T) 97, Heart Rate (HR) 80, Respiratory Rate (RR) 19 and Blood Pressure (BP) 130/72 mmHg at 6:37 AM.

Reference ranges for a normal adult vital signs obtained from the National Institute of Health/U.S. National Library of Medicine are as follows:
Temperature 97.8 to 99.1 F; Heart Rate 60-100 beats per minute; Respiratory Rate 12-18 breaths per minute; Blood Pressure 90/60 to 120/80 millimeter of mercury.

The September 2017 MAR indicated that the resident was prescribed and receiving oxygen 2 Liters per minute continuously via nasal cannula and ordered fluid restrictions for a total of 900 ml (milliliters) every shift, 600 ml dietary/300 ml nursing.

Review of the available facility nursing progress note dated on 09/14/17 at 7:43 PM, indicated as a
Continued From page 32

"late entry" by a Registered Nurse (RN) that she reported to duty at 7 PM and observed Resident #1 sitting up in bed in the hallway by the nurses station and had oxygen being administered continuously. The note indicated the resident was in stable condition, with no signs of respiratory distress, was afebrile (no fever) and respirations were even and unlabored. The nurse documented that the resident's vital signs were stable and fluids were offered and tolerated well.

Review of the available nursing progress note dated 09/13/17 at 5:01 AM by the RN night shift Nurse Manager indicated that Resident #1 was observed to be in respiratory distress. The resident's vital signs indicated BP 128/68, and 80% oxygen saturation rate on room air with 15 liters via non-breather, which improved to 92% oxygen saturation. 911 was called and the resident was transferred via Emergency Medical Services (EMS) to the hospital for evaluation. According to MayoClinic.org website, normal pulse oximeter readings for oxygen saturation rates usually range from 95 to 100 percent. Values under 90 percent are considered low.

In an interview with the RN night shift Nurse Manager on 09/13/2017 starting at 12:32 PM, he stated he began his shift on 09/12/17 at 7 PM and had received report that "all residents were stable and everything was under control." He stated that he had instructed the nurses on duty to monitor all the residents and provide ice water every 1 hour. He recalled around 1:30 AM, he was called to resident #1’s room, where Resident #1 was observed in respiratory distress. He stated the resident's lips were bluish in color and after he assessed did not require CPR (cardiopulmonary resuscitation). He stated that he applied additional oxygen and the resident's
Continued From page 33

vital signs were stable. He stated that 911 was called and Resident #1 was transferred by EMS to the hospital for evaluation. He stated that Resident #1 was alive and breathing on transfer.

Review of the hospital clinical record revealed Resident #1 arrived to the hospital Emergency Department (ED) via EMS on 09/13/17 at 3:24 AM with a chief complaint of altered mental status.

Review of the ED Registered Nurse (RN) Triage note dated 09/13/17 at 3:29 AM documents, ‘Rescue call for code, patient found non-verbal, with tympanic (taken in the ear) temp 107. Per rescue facility does not have AC (air conditioning).’

Review of the ED clinical record revealed initial vital signs documented on 09/13/17 at 3:30 AM by the ED RN to include a temperature of 40.7 degrees Celsius (C) (105.3 Fahrenheit (F) via axillary route (under arm pit). Resident #1’s BP is documented as 100/57; HR 150; RR 27. Emergent treatment was commenced on arrival to the ED.

Further review of the ED clinical record revealed Resident #1 deteriorated rapidly and required emergent endotracheal tube intubation and mechanical ventilation for acute respiratory failure on 09/13/17 at 3:39 AM.

On 09/13/17 at 3:43 AM, Resident #1’s core temperature is documented as 41.7 degrees C. (107.1 F).

On 09/13/17 at 4:20 AM, Resident #1’s core temperature is documented as 41 degrees C. (105.8 degrees F).
N 216 | Continued From page 34 | N 216

Review of documentation by the ED RN dated 09/13/17 at 4:30 AM states Resident #1
'Received 5 liters of cold normal saline and ice packs were applied to underarms, groin and posterior neck and the temperature in the room was decreased to 55 degrees F.'

Further review of the ED clinical record dated 09/13/17 at 7:30 AM, revealed Resident #1’s BP was dropping necessitating the initiation of an intravenous Dopamine drip to sustain blood pressure and subsequently intravenous Levophed, an additional medication to sustain blood pressure.

On 09/13/17 at 7:53 AM an ED physician progress note documented under Assessment/Plan - ‘Hyperthermia of 107 degrees Fahrenheit; presumed non-exertional heatstroke since nursing home has been without power since hurricane. Patient received IV fluid and cold water baths and fanning. Temp dropped to 41 C after the treatment and is now 37.8 C.’

On 09/13/17 at 8:15 AM, the residents’ health care surrogate made the decision to withdraw any further life support measures.

On 09/13/17 at 9:10 AM, an intravenous Morphine drip was commenced.

On 09/13/17 at 9:22 AM, the mechanical ventilation was discontinued and the oral endotracheal tube was removed.

On 09/13/17 at 3:09 PM Resident #1 was pronounced by the physician; patient pulseless with no respirations.
The Clinical Impression as documented in the clinical record by the ED physician after initial assessment on 09/13/17 at 3:34 AM, states under Diagnosis, 'Heat stroke.' The Merriam-Webster Medline Plus Medical Dictionary definition "heat stroke" is "a life-threatening condition characterized by cessation of sweating with inadequate elimination of body heat, extremely high temperature, rapid pulse, hot dry skin, flaccid muscles, delirium, collapse, and coma and resulting from prolonged exposure to high environmental temperature which causes a dysfunction of the temperature-regulating mechanism of the body".

b) Review of medical records available for Resident #2 on 09/15/17 indicated the resident was admitted to the facility on 06/26/17 with medical diagnoses including peripheral vascular disease (PVD), history of transient ischemic attack (TIA), cough, dementia, dysphagia (difficulty swallowing), history of pneumonia status post aspiration, and percutaneous endoscopic gastrostomy (PEG) feeding tube placement for nutritional and hydration needs.

Review of the quarterly MDS with an ARD of 05/04/17 documented the resident has severe cognitive impairment and is totally dependent on nursing staff for mobility and ADLs.

Further review of the record indicated on 09/12/17 at 7:11 PM, Resident #2 was assessed with no respiratory distress, but had an axillary (under armpit) temperature of 99.8 degrees F. The RN notified the health care provider and administered Tylenol 325 milligrams via the PEG tube. A follow-up temperature indicated a decrease in temperature to 98.8 degrees F. Further review of the record indicated no
Continued From page 36

additional temperature monitoring conducted. Review of the progress note dated on 09/13/17 at 4:42 AM indicated the RN observed Resident # 2 to have shortness of breath (SOB) and positive breath sounds for rhonchi. The note indicated the RN suctioned the resident twice and vital signs were taken, BP 126/ 78, HR 104, RR 24, labored, and T 101.6 degrees F. The resident was assessed to have 77% oxygen saturation on room air and oxygen was applied. 911 was called and Resident #2 was transferred by EMS to the hospital for evaluation.

In an interview with the RN night shift Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that earlier in the evening, he had observed Resident #2 in the 2nd floor hallway, near a portable AC cooler. He stated that at approximately 2:30 AM on 09/13/2017, he was called by staff to Resident #2’s room, observed in respiratory distress, and foaming at the mouth. He stated that he suctioned the resident’s mouth and told a staff to call 911 for EMS transfer to the hospital for evaluation.

Review of the hospital clinical record revealed Resident #2 arrived to the hospital ED via EMS on 09/13/17 at 4:32 AM with a chief complaint of cardiac arrest.

Review of the ED clinical record dated 09/13/17 at 4:34 AM completed by the ED physician documents 'Patient presents to ED via EMS from nursing home as a code heart today. Per EMS the patient was found to have a temp of 107 on scene.'

Review of the hospital Vital Signs log documents the initial temperature taken on 09/13/17 at 4:33 AM was 42.4 C (108.3 F). Resident #2 did not
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

REHABILITATION CENTER AT HOLLYWOOD HILLS, L
1200 N 35TH AVE
HOLLYWOOD, FL 33021

NAME OF PROVIDER OR SUPPLIER
STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING: ______________________
B. WING ________________________

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have a recordable pulse or blood pressure.

Further review of the ED clinical record revealed documentation dated 09/13/17 at 4:33 AM completed by the ED RN stating ‘Resident from (name of nursing home). Nursing staff called 911 for complaints of fever. On arrival patient noted to be in cardiac arrest with CPR in progress. EMS states conditions of facility were untenable due to lack of functioning AC. EMS states they did not fans however they were inadequate in relationship to patient’s location whereabouts.’

Review of the ED Course documentation by the ED physician dated 09/13/17 commencing at 4:34 AM and continuing to 5:00 AM, documents ‘Per rescue patient was hyperthermic (an increased temperature in the body), (confirmed in the ED) with asystolic (flat line heart rhythm) arrest. ACLS (advanced cardiac life support) initiated in the field and continued in the ED. No sustained rhythm despite ACLS. Patient pronounced.’

Despite resuscitative efforts in the ED, Resident #2 was pronounced dead at 5:00 AM on 09/13/17.

c) Resident #3 was admitted to the facility on 06/30/16 and subsequently admitted to hospice services on 10/16/16. Review of the clinical record revealed the last documented physician hospice note in the chart dated 08/01/17 documents ‘Resident with history of end stage heart failure, history of hypertension, weakness, and aspiration.’ Review of the hospice records dated 09/06/17 documents the resident was exhibiting agitation requiring medications. There is no further documentation regarding the resident’s status up to 09/12/17, 2 days after the hurricane, when was assessed by the
Continued From page 38

physician to be experiencing multi system decline including respiratory distress. The resident was subsequently placed on 24-hour hospice bedside nursing care for comfort measures. Review of the facility Vital Signs record revealed the last documented temperature is 97 degrees F dated 09/12/17 at 12:00 AM.

Review of the hospice Continuous Care Shift Care Note dated 09/12/17 at 8:00 PM documents the resident’s temperature is 99.5 degrees F with a respiratory rate of 36. Further review of the note documents at 9:00 PM the resident’s temperature is 102.5 degrees F. Resident #3 was administered Tylenol at 9:00 PM on 09/12/17. On 09/12/17 at 10:00 PM, Resident #3’s temperature was 102 degrees F with a heart rate of 115 and respiratory rate of 42. Review of the Continuous Care Shift Care Note the hospice Licensed Practical Nurse documented at 10:00 PM ‘SOB (shortness of breath), head of bed up to facilitate ease of breathing; cool room with fan to facilitate of the air circulation of the room maintained.’ Resident #3 expired on 09/13/17 at 1:35 AM with the hospice nurse at bedside.

d) Resident #4 was admitted to the nursing home on 10/17/15 with diagnoses to include dementia, hypertension, congestive heart failure, peripheral vascular disease, right above knee amputation, anemia, and atherosclerotic heart disease. Resident #4 had ‘Full Code’ cardiac resuscitation directives.

Review of the quarterly MDS with an ARD of 04/19/17 documents the resident scored a 6 out of 15 on the BIMS indicating severe cognitive impairment with functional status requiring extensive assistance from nursing staff for mobility and ADLs.
### N 216

Continued From page 39

Review of the facility Vital Signs record dated 09/13/17 at 1:28 AM documents the resident’s T at 97 degrees F, HR of 74 and RR of 18, and at 1:29 AM, the resident’s blood pressure is documented as 128/74. There are no further vital signs or temperatures documented in the clinical record reviewed.

Review of Resident #4’s clinical record revealed a Nursing Progress Note dated 09/14/17 at 7:42 PM the Licensed Practical Nurse (LPN) documented, 'Late entry: Patient received at 11:15 PM (no date documented) resting in bed, no distress noted. Respiration even and non-laborated. Blood pressure within normal limits, afebrile. Remain in stable condition.'

The next entry in the Nursing Progress Notes dated 09/14/17 at 7:54 PM by the LPN documented, 'Late entry: approximately 4:00 AM patient noted cardiac arrest with shallow breathing. BP 90/56, RR 15, HR 52. Non-rebreather applied, heart rate ceased. CPR initiated. 911 called. Rescue arrived pronounced resident death.'

Further review of Resident #4’s clinical record revealed no evidence of documentation when EMS arrived; no documentation of the time the EMS pronounced the resident’s death; no documentation the resident’s physician or family were notified of death.

In an interview with the RN night Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that at approximately 4:30 AM, he was called to resident #4’s room, where Resident #4 was found unresponsive and he immediately began to perform CPR since the resident had full
<table>
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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| N 216         | Continued From page 40 code resuscitation status. The RN night Nurse Manager stated that he instructed a staff member to call 911 and when the EMS arrived, they evaluated Resident #4 and instructed him to stop performing CPR. He stated that while EMS was on site in Resident #4's room, a roommate, Resident #5, was observed by staff, not to be breathing. The RN night Nurse Manager stated that CPR was not initiated due to Resident #5's "Do Not Resuscitate" (DNR) directive. e) Review of medical records available for Resident #5 on 09/15/17 indicated the resident was admitted to the facility on 05/09/03 with medical diagnoses including cardiac disease, hypertension, history of head injury, TIA (Transient Ischemic Attack), cellulitis of the abdominal wall, PEG placement, dementia, dysphagia, chronic pain, multiple contracture sites, incontinence of bowel and bladder, aphasia (inability to verbally express oneself) and impaired mobility. Review of a significant change MDS with an ARD of 05/12/17 documented the resident had severe cognitive impairment and was totally dependent on nursing staff for mobility and ADLs. Review of Resident #5's vital signs monitoring indicated on 09/12/17 at 2:20 PM- T 98.6, RR 16, HR 76, and BP 126/72. Review of available medical record progress notes dated on 09/14/17 at “8:15 as a late entry”- indicated Resident #5 was observed at 11:15 (the time documented did not indicate AM or PM) to be resting in bed with respirations that were even and unlabored. No additional documentation was available for review. As indicated above, Resident #5 was evaluated by EMS after attending to Resident #4 and pronounced dead by EMS.
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<td>(Emergency Medical Service) while on site according to the interview conducted on 09/13/17 at 12:32 PM with the RN night Nurse Manager.</td>
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<td>f) Review of medical records available for Resident #6 on 09/15/17 indicated that the resident was admitted to the facility on 02/09/17 with medical diagnoses including hypertension, COPD with exacerbation, bronchitis, asthma, benign prostatic hyperplasia (BPH), history of falls, generalized weakness, functional decline, history of urinary tract infection (UTI), incontinence of bowel and bladder and pressure wounds.</td>
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<td>Review of the quarterly MDS with an ARD of 08/16/17 documents the resident scored a 15 out of 15 on the BIMS, indicating no cognitive impairment, with functional status requiring extensive assistance from nursing staff for mobility and ADLs.</td>
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<td>Review of the September 2017 MAR indicated the last documentation on 09/13/17 at 1:42 AM- T 97, HR 69, RR 18, and BP 120/76. Review of progress notes indicated the last entry, dated on 09/04/17, which revealed the resident refused shower and was given a bed bath instead.</td>
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<td>In an interview with the RN night Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that at approximately 4:30 AM, staff notified him that Resident # 6, was found to be unresponsive and not breathing. He stated that EMS personnel were already in the facility, and initiated CPR, due to the resident's full code directive status and EMS personnel pronounced the resident death. The nurse stated that the resident had not exhibited any signs of distress prior to death.</td>
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g) Review of medical records available for Resident #7 on 09/15/17 indicated that the resident was admitted to the facility on 09/12/15 with medical diagnoses including cerebral infarction with cerebrovascular accident (CVA), aphasia, hypertension, cardiovascular disease, generalized muscle weakness, history of UTI, protein malnutrition, dysphagia and PEG tube placement.

Review of the quarterly MDS with an ARD of 06/18/17 documented the resident had severe cognitive impairment and is totally dependent on nursing staff for mobility and ADLs.

Record review indicated the last vital signs taken on 09/12/17 at 10:34 PM, were documented as T 97, HR 70, RR 16 and BP 122/74. The last nursing note entry was dated on 08/09/17 at 10:53 PM, which indicated the resident was stable.

Review of the hospital clinical record revealed Resident #7 arrived to the hospital ED via EMS on 09/13/17 at 7:03 AM with a chief complaint of shortness of breath.

Review of the EMS Initial Patient Assessment form dated 09/13/17 documented their patient contact at the facility was at 6:55 AM. The narrative of events included altered mental status, hyperthermia and respiratory distress. The patient's temperature is documented as 103.3 degrees F and skin temperature as feeling hot.

Review of the ED clinical record revealed documentation by the ED RN dated 09/13/17 at 7:05 AM stating 'Received patient from a nursing facility for fever and unresponsive. Per EMS
nursing facility has no air conditioning and patient possible has heat exhaustion. Patient arrived on a non-rebreather with labored shallow respirations. Cardiac monitor applied. Patient is pulseless, CPR initiated.'

Review of the ED clinical record revealed documentation by the ED physician dated 09/13/17 at 7:10 AM states, *Patient with history of hypertension presents to the ED with SOB onset PTA (prior to arrival). Patient was brought in by EMS from (name of facility). They have not had electricity since Monday due to the hurricane. was brought in with SOB and became unresponsive with asystole on arrival.*

Resuscitative efforts were commenced in the ED.

Resident #7's temperature on 09/13/17 at 7:50 AM is documented in the ED record as 42.5 degrees C rectally (108.5 degrees F).

Despite resuscitative efforts, Resident #7 expired at 7:54 AM in the ED.

h) Review of medical records available for Resident #8 on 09/15/17 indicated that the resident was admitted to the facility on 11/17/09 with medical diagnoses including heart disease, hypertension, CVA, hemiplegia (paralysis to one side of the body), convulsions, and atrial fibrillation.

Review of the quarterly MDS with an ARD of 08/15/17 documented a BIMS score of 14 out of 15, which indicated the resident was cognitively intact and was totally dependent on nursing staff for mobility and ADLs.

Further review of the record indicated the vital
Continued From page 44

signs on 09/12/17 at 4:16 AM, the resident had a temperature of 102 degrees F and Tylenol 650 mg was administered as ordered. Follow-up vital sign monitoring on 09/12/17 at 2:18 PM indicated - T 98.2, RR 16, HR 70, and BP 134/76.

Review of the progress note dated on 09/13/17 at 3:31 AM, written by the LPN, indicated that Resident #8 was observed to be alert with flushed, clammy skin. Vital sign monitoring revealed - BP 148/76, HR 79, RR 19, T 101 degrees F, with 88% oxygen saturation on room air. Oxygen at 2 liters via nasal cannula was administered to the resident with an increase to 96% oxygen saturation. Tylenol was administered as ordered for fever. Further review of the progress note, time stamped on "09/14/17 at 8:05 PM" indicated "late entry" the LPN documented stating at approximately 4:20 AM Resident #8 had a change of condition and was observed in respiratory distress. The note further indicated the resident's respiratory rate was 28 breaths per minute, rapid and labored and oxygen was applied. 911 was called to transfer the resident by EMS to the hospital for evaluation.

Review of the hospital clinical record revealed Resident #8 arrived to the hospital ED via EMS on 09/13/17 at 6:42 AM with a chief complaint of cardiac arrest and severe hyperthermia.

Review of the ED record revealed Resident #8 was pronounced dead at 6:49 AM on 09/13/17.

Review of the ED Vital Signs documentation revealed Resident #8's temperature taken following death on 09/13/17 at 7:04 AM was 43.3 degrees C (109.9 F) rectally.

Review of the ED physician summary
### N 216

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Documentation dated 09/13/17 at 7:47 AM states in part, the patient who presents to the Emergency Department with a chief complaint of cardiac arrest. Patient has a medical history of hypertension, hypothyroidism, seizure disorder, history of stroke is likely bed bound patient arriving from skilled nursing facility. Patient arrives extremely hyperthermic, in asystolic cardiac arrest ...pulse check was performed every 3-5 minutes. The patient continued to be in asystolic arrest bedside ultrasound shows no cardiac activity.¹

The ED physician further documented on 09/13/17 at 7:47 AM, ‘In summary arriving from a skilled nursing facility in asystolic cardiac arrest very hyperthermic, cold fluids were administered in the emergency department. Patient remained asystolic on the monitor. No cardiac activity was noted on any of the ultrasound checks. No obvious reversible cause to explain asystolic arrest. The patient was pronounced dead by me. Team was in agreement to call code. RN attempting to call family.’

On 09/13/17 at 1:30 PM during the interview with the Administrator and DON, the Administrator stated the local law enforcement police chief contacted him at approximately 5:30 AM to inform him they were conducting a mandatory evacuation of the facility due to the excessive temperatures inside the building. The Administrator stated he arrived to the facility around 6:00 AM and he observed residents were evacuated to the outside. The DON stated at this time she too was notified by facility staff around 5:30 AM to inform her the police chief was in the process of evacuating the second floor due to excessive high temperatures and when she arrived all the residents from the second floor...
Continued From page 46

been moved to the first floor or outside with staff. On 09/15/17 at 9:31 AM, a telephone interview was conducted with the DON inquiring if she was able to produce a staffing list for the days post the hurricane. She stated she does not have access to her office as the facility is under lock down by the local police, however she will attempt to compile a list from memory and it may not be all-inclusive.

The hand written nursing staffing list provided by the DON via email on 09/15/17 at 4:37 PM was reviewed. Review of the provided staffing list revealed on Monday September 11, 2017 on the day shift from 7:00 AM to 7:00 PM the number of licensed nursing staff for the first and second floors included 5 Licensed Practical Nurses (LPN), 10 Certified Nursing Assistants (CNA), 1 Registered Nurse (RN) and 2 Minimum Data Set (MDS) licensed nurses. Additionally, the DON was on site in the facility until 1:00 PM to 1:30 PM and the Administrator was on site in the facility until approximately 7:00 PM.

Review of the Monday, September 11, 2017 night shift staffing list from 7:00 PM to 7:00 AM the number of licensed nursing staff for the first and second floors included 4 LPN's and 9 CNA's.

Review of the Tuesday, September 12, 2017 day shift staffing list from 7:00 AM to 7:00 PM the number of licensed nursing staff for the first and second floors included 5 LPN's, 1 RN, 15 CNA's, 2 wound care LPN's and 1 MDS licensed nurse. Additionally, there was a hospice LPN on site providing continuous comfort care at the bedside of Resident #3.

Review of the Tuesday, September 12, 2017 night shift staffing list from 7:00 PM to 7:00 AM
Continued From page 47

the number of licensed nursing staff for the first and second floors included 4 LPN's, 3 RN's, and 5 CNAs. Additionally, there was a hospice LPN who commenced a night shift at 11:30 PM for continuous comfort care at the bedside of Resident #3. Further, the Administrator was on site in the facility until approximately 11:00 PM to 11:30 PM.

As discussed with the Administrator during the interview on 09/13/17 at 1:20 PM he confirmed the facility day-to-day functions were not affected by the power failure to the AC unit and the routine dietary and housekeeping services were still being provided.

Review of the Florida Department of Children and Families web site reveals an abuse hot line is available 24 hours a day, 7 days a week, which states, "Serves as a central reporting center for allegations of abuse and neglect and/ or exploitation for all children and vulnerable adults in Florida ... .... Persons mandated to report suspected abuse or neglect include Nursing Home staff."

Class 1
F 000  INITIAL COMMENTS

An unannounced complaint survey for #2017010920 was conducted from September 13, 2017 through September 22, 2017 at Rehabilitation Center at Hollywood Hills, LLC. Rehabilitation Center at Hollywood Hills, LLC, was not in compliance with Requirements of 42 CFR Part 483, Requirements for Long Term Care Facilities at the time of this survey. The complaint allegation for Quality of Care/Treatment was substantiated.

Non-compliance was identified for F223, F252, F309, and F490 at a severity and scope of K, Immediate Jeopardy at a pattern.

Substandard Quality of Care was identified at F223, F252, and F309.

An extended survey was not conducted due to the facility being closed related to multiple incidents affecting the health and safety of residents.

The nursing home's central air conditioning system became inoperable from the afternoon of September 10, 2017 through the early morning of September 13, 2017, after Hurricane Irma occurred. The facility residents were exposed to increasingly excessive heat, which caused 8 vulnerable residents to have severe heat-related conditions. These 8 residents consequently died on September 13, 2017. Six of 8 residents died from 4:30 AM to 7:54 AM on September 13, 2017. The other facility residents were evacuated to the hospital across the street to protect them from potential serious harm. At the initial time of the survey, the census was 141 residents.
F 223
SS=K

483.12
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s symptoms.

483.12(a) The facility must-
(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility staff failed to ensure 8 of 8 vulnerable residents out of 59 residents residing on the second floor of the facility were free from neglect, (Resident #1, #2, #3, #4, #5, #6, #7 and #8. The facility's central air conditioning system became inoperable from the afternoon of September 10, 2017 through the early morning of September 13, 2017, after Hurricane Irma occurred. The facility residents were exposed to increasingly excessive heat, which caused the 8 affected residents to have serious heat-related conditions and these residents consequently died. The other facility residents were evacuated to the hospital across the street to protect them from potential serious harm. The facility's failure to provide the necessary goods and services to avoid residents' physical harm, pain, mental anguish, or emotional distress, resulted in immediate jeopardy. Cross refer to F252, F309, and F490.

The findings included:
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<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETED DATE</th>
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<td>F 223</td>
<td>Continued From page 2</td>
<td>1. Review of the facility's 2017 Emergency Management Plan, approved by the Broward County Emergency Management Division on July 21, 2017 revealed, the facility had contractual agreements with another long-term care facility and transportation company for emergency or evacuation purposes. These services were not activated after a major hurricane rendering the facility without air conditioning (AC) for approximately 62 hours or approximately 3 days. Additionally, the nursing home is located directly across the street from a large 621 bed local hospital, which did not lose power or AC during or after the hurricane. According to Google Maps, the facility is located 0.2 miles (1056 feet) from the front door of the facility to the front door of the local hospital. On 09/13/17 at approximately 12:30 PM, an interview was conducted with the facility Director of Engineering who stated at approximately 3:49 PM on 09/10/17 he heard a bang outside and determined a transformer located on a pole across the street had been hit by a tree. He stated at that time he began checking the AC function within various parts of the building. He stated the inside temperature was up to 77 degrees Fahrenheit (F) due to the AC chiller not functioning as a result of the blown transformer. He further stated the malfunctioning line was the dedicated electric line to the facility AC chiller. Additionally he stated the facility never lost power during the storm and as a result, the generator was not needed. He confirmed the generator the facility had on site was not powerful enough to run the AC and the AC could not be connected to that generator. He further stated on site they had 10 rented portable AC units and fans and he</td>
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started to set them up immediately when he determined the central AC malfunctioned. He stated he started to set up 2 in the adjoined behavioral hospital, and in the nursing home they set up 3 on the second floor and 4 on the first floor with one of the 10 units malfunctioning. Additionally he stated he placed fans in each resident room and large industrial fans set up in the hallways.

On 09/13/17 at 1:20 PM, an interview was conducted with the facility Administrator and Director of Nurses (DON). At the time of the interview on 09/13/17 at 1:20 PM, the power to the facility’s AC unit had not been restored yet per the Administrator. The Administrator stated he was onsite from Friday 09/08/17 around 1:30 PM to 2:00 PM and never left the facility until Monday 09/11/17 around 7:00 PM to 7:30 PM. He stated he had been active on the daily Florida Health STAT Database reporting system and he had notified the state agency he would not be accepting any new residents due to the AC issues. He stated he left the facility last night (09/12/17) at around 11:00 PM - 11:30 PM and he received no report of resident concerns upon exiting. The DON stated, during the interview on 09/13/17 at approximately 1:30 PM she remained in the facility on 09/08/17 through 09/11/17 leaving the facility around 1:30 PM. She stated, she had instructed the nurses and aides to monitor the residents frequently and offer water and ice every hour.

On 09/25/17 at 4:06 PM, a telephone interview was conducted with a state agency fire protection specialist who reviewed his facility file and determined the approximate square footage on the second floor of the facility was 16,000 square
F 223 Continued From page 4

feet with 8-9 foot ceilings. During the interview with the fire protection specialist, it could not be determined how many square feet each portable AC unit could effectively cool.

2. Review of Florida Governor, Rick Scott's released timeline dated September 19, 2017, the following was documented:

"On Sunday, September 10, 2017 at 6:46 PM, the (name of facility) was again notified by the state to report updates to the FL Health STAT Database on post-storm Hurricane Irma response. The facility was asked to provide updates to the database at least twice a day. However if significant changes occurred, they would have to report additional updates. All ALF's, nursing homes and hospitals were asked to comply. On Sunday, September 10, 2017 at 6:51 PM, the (name of nursing home) reported through the FL Health STAT Database that they were closed but that everything was operational, including heating and cooling."

"On Monday, September 11, 2017 at 7:30 AM, the (name of facility) previously provided update was counted as their current status in the FL Health STAT Database since they did not report any changes. Per this report, everything remained operational at the (name of facility)."

"On Monday, September 11, 2017 at 5:37 PM, the (name of facility) called the Florida Emergency Information Line, a toll-free hotline activated at the time of an emergency to provide an additional resource for those in Florida to receive accurate and up-to-date information. This line is an information only line for Floridians and is not meant to replace 911."
Continued From page 5

"On Tuesday, September 12, 2017 at 1:30 PM, the (name of facility) previously provided update was counted as their current status in the FL Health STAT Database since they did not report any changes."

"On Tuesday, September 12, 2017 at 2:00 PM, as part of all impacted counties daily submissions, Broward County submitted a situation report to the state Division of Emergency Management that included an update on all health and medical aspects of storm response in Broward County. Included in this report was a note that the (name of facility) is running on generator power without air conditioning, which is adversely affecting patients, and that a ticket had been put into the power company to ensure priority status."

"On Tuesday, September 12, 2017 at 4:17 PM, a state representative returned the call left on the Governor's personal cell phone by contacting (facility Administrator). The Administrator reported that the (name of facility) was open, that the chiller was not operational pulling outside air but that they had spot coolers and fans, and that power was partial. The Administrator did not, at any time during the call, report or indicate that conditions had become dangerous or that the health and safety of their patients was at risk. State representative advised Administrator to call 911 if there was any reason to believe that the health or safety of patients was at risk."

The timeline indicated the AC power went out on 09/10/17 at approximately 3:49 PM and as of 09/12/17 at 4:17 PM, the facility was still without functioning central air conditioning for approximately 47 consecutive hours. The
Continued From page 6

Administrator did not report or indicate any conditions that had become dangerous or posed a risk to the residents and as of 09/13/17 at approximately 3:00 AM, per the time line, the first patient was taken emergently to the hospital from the facility in critical condition.

3. Review of the Weather Underground.com web site temperature readings from the weather station at the Fort Lauderdale/Hollywood International Airport, located 6 land miles from the facility, indicated for 09/11/17 at 5:53 PM the outside temperature was 89.6 degrees F with a heat index of 96.2 F and humidity of 55%.

On 09/11/17 at 11:55 PM, the outside temperature was 80.6 degrees F with a heat index of 86.2 degrees and humidity of 84%.

On 09/12/17 at 7:53 AM, the outside temperature was 78.8 degrees F with a humidity of 89%.

On 09/12/17 at 12:53 PM, the outside temperature was 87.8 degrees F with a heat index of 95.6 degrees F and humidity of 62%.

On 09/12/17 at 6:53 PM, the outside temperature was 87.8 degrees F with a heat index of 92.6 degrees F and humidity of 55%.

On 09/12/17 at 10:53 PM, the outside temperature was 82.9 degrees F with a heat index of 91.8 degrees F and humidity of 82%.

On 09/13/17 at 1:53 AM, the outside temperature was 82 degrees F with a heat index of 89.4 degrees F with humidity of 82%.

On 09/13/17 at 4:53 AM, the outside temperature
A. BUILDING ______________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

X1) STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

X3) DATE SURVEY COMPLETED

PRINTED: 10/13/2017

FORM APPROVED

OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER

REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

1200 N 35TH AVE

HOLLYWOOD, FL 33021

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

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was 79 degrees F with 88% humidity.

F 223

Reference ranges for a normal adult vital signs obtained from the National Institute of Health/U.S. National Library of Medicine are as follows:

Temperature 97.8 to 99.1 F; Heart Rate 60-100 beats per minute; Respiratory Rate 12-18 breaths per minute; Blood Pressure 90/60 to 120/80 millimeter of mercury.

The September 2017 MAR indicated that the

4. a) Review of medical records available for Resident #1 on 09/15/17 indicated Resident #1 was admitted to the facility on 09/28/15 with medical diagnoses including Chronic Obstructive Pulmonary Disease (COPD), heart failure, hypertension, atrial fibrillation, diabetes and dyspnea (difficulty breathing).

Review of the Federally required comprehensive resident assessment, referred to as the MDS (Minimum Data Set) quarterly assessment with an Assessment Reference date (ARD) of 04/07/17 documents under Cognitive Pattern the resident scored a 15 out of 15 on the BIMS (brief interview of mental status) scale and Functional Status is documented as extensive assistance from nursing staff for mobility and ADLs (activities of daily living).

Further review of the medical record indicated that Resident #1’s vital signs were being monitored. Review of the September 2017 Medication Administration Record (MAR), 'last entry' dated 09/11/17 at 11:53 PM indicated Temperature (T) 97, Heart Rate (HR) 80, Respiratory Rate (RR) 19 and Blood Pressure (BP)130/72 mmHg at 6:37 AM.
Continued From page 8

Resident was prescribed and receiving oxygen 2 liters per minute continuously via nasal cannula and ordered fluid restrictions for a total of 900 ml (milliliters) every shift, 600 ml dietary/300 ml nursing.

Review of the available facility nursing progress note dated on 09/14/17 at 7:43 PM, indicated as a "late entry" by a Registered Nurse (RN) that she reported to duty at 7 PM and observed Resident #1 sitting up in bed in the hallway by the nurses station and had oxygen being administered continuously. The note indicated the resident was in stable condition, with no signs of respiratory distress, was afebrile (no fever) and respirations were even and unlabored. The nurse documented that the resident's vital signs were stable and fluids were offered and tolerated well.

Review of the available nursing progress note dated 09/13/17 at 5:01 AM by the RN night shift Nurse Manager indicated that Resident #1 was observed to be in respiratory distress. The resident's vital signs indicated BP 128/68, and 80% oxygen saturation rate on room air with 15 liters via non-breather, which improved to 92% oxygen saturation. 911 was called and the resident was transferred via Emergency Medical Services (EMS) to the hospital for evaluation. According to MayoClinic.org website, normal pulse oximeter readings for oxygen saturation rates usually range from 95 to 100 percent. Values under 90 percent are considered low.

In an interview with the RN night shift Nurse Manager on 09/13/2017 starting at 12:32 PM, he stated he began his shift on 09/12/17 at 7 PM and had received report that "all residents were stable and everything was under control." He stated that
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<th>F 223</th>
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<td>he had instructed the nurses on duty to monitor all the residents and provide ice water every 1 hour. He recalled around 1:30 AM, he was called to resident #1’s room, where Resident #1 was observed in respiratory distress. He stated the resident’s lips were bluish in color and after he assessed did not require CPR (cardiopulmonary resuscitation). He stated that he applied additional oxygen and the resident’s vital signs were stable. He stated that 911 was called and Resident #1 was transferred by EMS to the hospital for evaluation. He stated that Resident #1 was alive and breathing on transfer.</td>
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### F 223

Continued From page 10

Mechanical ventilation for acute respiratory failure on 09/13/17 at 3:39 AM.

On 09/13/17 at 3:43 AM, Resident #1's core temperature is documented as 41.7 degrees C. (107.1 F).

On 09/13/17 at 4:20 AM, Resident #1's core temperature is documented as 41 degrees C. (105.8 degrees F).

Review of documentation by the ED RN dated 09/13/17 at 4:30 AM states Resident #1 'Received 5 liters of cold normal saline and ice packs were applied to underarms, and posterior neck and the temperature in the room was decreased to 55 degrees F.'

Further review of the ED clinical record dated 09/13/17 at 7:30 AM, revealed Resident #1's BP was dropping necessitating the initiation of an intravenous Dopamine drip to sustain blood pressure and subsequently intravenous Levophed, an additional medication to sustain blood pressure.

On 09/13/17 at 7:53 AM an ED physician progress note documented under Assessment/Plan - 'Hyperthermia of 107 degrees Fahrenheit; presumed non-exertional heatstroke since nursing home has been without power since hurricane. Patient received IV fluid and cold water baths and fanning. Temp dropped to 41 C after the treatment and is now 37.8 C.'

On 09/13/17 at 8:15 AM, the residents' health care surrogate made the decision to withdraw any further life support measures.
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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| F 223         | Continued From page 11  
On 09/13/17 at 9:10 AM, an intravenous Morphine drip was commenced.  
On 09/13/17 at 9:22 AM, the mechanical ventilation was discontinued and the oral endotracheal tube was removed.  
On 09/13/17 at 3:09 PM Resident #1 was pronounced by the physician; patient pulseless with no respirations.  
The Clinical Impression as documented in the clinical record by the ED physician after initial assessment on 09/13/17 at 3:34 AM, states under Diagnosis, 'Heat stroke.' The Merriam-Webster Medline Plus Medical Dictionary definition "heat stroke" is "a life-threatening condition characterized by cessation of sweating with inadequate elimination of body heat, extremely high temperature, rapid pulse, hot dry skin, flaccid muscles, delirium, collapse, and coma and resulting from prolonged exposure to high environmental temperature which causes a dysfunction of the temperature-regulating mechanism of the body".  
b) Review of medical records available for Resident #2 on 09/15/17 indicated the resident was admitted to the facility on 06/26/17 with medical diagnoses including peripheral vascular disease (PVD), history of transient ischemic attack (TIA), cough, dementia, dysphagia (difficulty swallowing), history of pneumonia status post aspiration, and percutaneous endoscopic gastrostomy (PEG) feeding tube placement for nutritional and hydration needs.  
Review of the quarterly MDS with an ARD of 05/04/17 documented the resident has severe | F 223 | | | |

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Review of the quarterly MDS with an ARD of 05/04/17 documented the resident has severe
Continued From page 12

cognitive impairment and is totally dependent on nursing staff for her mobility and ADLs.

Further review of the record indicated on 09/12/17 at 7:11 PM, Resident #2 was assessed with no respiratory distress, but had an axillary (under armpit) temperature of 99.8 degrees F. The RN notified the health care provider and administered Tylenol 325 milligrams via the PEG tube. A follow-up temperature indicated a decrease in temperature to 98.8 degrees F.

Further review of the record indicated no additional temperature monitoring conducted. Review of the progress note dated on 09/13/17 at 4:42 AM indicated the RN observed Resident # 2 to have shortness of breath (SOB) and positive breath sounds for rhonchi. The note indicated the RN suctioned the resident twice and vital signs were taken, BP 126/ 78, HR 104, RR 24, labored, and T 101.6 degrees F. The resident was assessed to have 77% oxygen saturation on room air and oxygen was applied. 911 was called and Resident #2 was transferred by EMS to the hospital for evaluation.

In an interview with the RN night shift Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that earlier in the evening, he had observed Resident #2 in the 2nd floor hallway, near a portable AC cooler. He stated that at approximately 2:30 AM on 09/13/2017, he was called by staff to Resident #2's room, observed in respiratory distress, and foaming at the mouth. He stated that he suctioned the resident's mouth and told a staff to call 911 for EMS transfer to the hospital for evaluation.

Review of the hospital clinical record revealed Resident #2 arrived to the hospital ED via EMS.
| F 223 | Continued From page 13 on 09/13/17 at 4:32 AM with a chief complaint of cardiac arrest. Review of the ED clinical record dated 09/13/17 at 4:34 AM completed by the ED physician documents 'Patient presents to ED via EMS from nursing home as a code heart today. Per EMS the patient was found to have a temp of 107 on scene.'  
Review of the hospital Vital Signs log documents the initial temperature taken on 09/13/17 at 4:33 AM was 42.4 C (108.3 F). Resident #2 did not have a recordable pulse or blood pressure.  
Further review of the ED clinical record revealed documentation dated 09/13/17 at 4:33 AM completed by the ED RN stating 'Resident from (name of nursing home). Nursing staff called 911 for complaints of fever. On arrival patient noted to be in cardiac arrest with CPR in progress. EMS states conditions of facility were untenable due to lack of functioning AC. EMS states they did note fans however they were inadequate in relationship to patient's location whereabouts.'  
Review of the ED Course documentation by the ED physician dated 09/13/17 commencing at 4:34 AM and continuing to 5:00 AM, documents 'Per rescue patient was hyperthermic (an increased temperature in the body), (confirmed in the ED) with asystolic (flat line heart rhythm) arrest. ACLS (advanced cardiac life support) initiated in the field and continued in the ED. No sustained rhythm despite ACLS. Patient pronounced.'  
Despite resuscitative efforts in the ED, Resident #2 was pronounced dead at 5:00 AM on 09/13/17. | F 223 |
c) Resident #3 was admitted to the facility on 06/30/16 and subsequently admitted to hospice services on 10/16/16. Review of the clinical record revealed the last documented physician hospice note in the chart dated 08/01/17 documents 'Resident with history of end stage heart failure, history of hypertension, weakness, and aspiration.' Review of the hospice records dated 09/06/17 documents the resident was exhibiting agitation requiring medications. There is no further documentation regarding the resident's status up to 09/12/17, 2 days after the hurricane, when was assessed by the physician to be experiencing multi system decline including respiratory distress. The resident was subsequently placed on 24-hour hospice bedside nursing care for comfort measures. Review of the facility Vital Signs record revealed the last documented temperature is 97 degrees F dated 09/12/17 at 12:00 AM.

Review of the hospice Continuous Care Shift Care Note dated 09/12/17 at 8:00 PM documents the resident's temperature is 99.5 degrees F with a respiratory rate of 36. Further review of the note documents at 9:00 PM the resident's temperature is 102.5 degrees F. Resident #3 was administered Tylenol at 9:00 PM on 09/12/17. On 09/12/17 at 10:00 PM, Resident #3's temperature was 102 degrees F with a heart rate of 115 and respiratory rate of 42. Review of the Continuous Care Shift Care Note the hospice Licensed Practical Nurse documented at 10:00 PM 'SOB (shortness of breath), head of bed up to facilitate ease of breathing; cool room with fan to facilitate of the air circulation of the room maintained.' Resident #3 expired on 9/13/17 at 1:35 AM with the hospice nurse at bedside.
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d) Resident #4 was admitted to the nursing home on 10/17/15 with diagnoses to include dementia, hypertension, congestive heart failure, peripheral vascular disease, right above knee amputation, anemia, and atherosclerotic heart disease. Resident #4 had ‘Full Code’ cardiac resuscitation directives.

Review of the quarterly MDS with an ARD of 04/19/17 documents the resident scored a 6 out of 15 on the BIMS indicating severe cognitive impairment with functional status requiring extensive assistance from nursing staff for mobility and ADLs.

Review of the facility Vital Signs record dated 09/13/17 at 1:28 AM documents the resident’s T at 97 degrees F, HR of 74 and RR of 18, and at 1:29 AM, the resident's blood pressure is documented as 128/74. There are no further vital signs or temperatures documented in the clinical record reviewed.

Review of Resident #4’s clinical record revealed a Nursing Progress Note dated 09/14/17 at 7:42 PM the Licensed Practical Nurse (LPN) documented, 'Late entry: Patient received at 11:15 PM (no date documented) resting in bed, no distress noted. Respiration even and non-labored. Blood pressure within normal limits, afebrile. Remain in stable condition.'

The next entry in the Nursing Progress Notes dated 09/14/17 at 7:54 PM by the LPN documented, 'Late entry: approximately 4:00 AM patient noted cardiac arrest with shallow breathing. BP 90/56, RR 15, HR 52. Non-rebreather applied, heart rate ceased. CPR
F 223 Continued From page 16
initiated. 911 called. Rescue arrived pronounced resident death.¹

Further review of Resident #4's clinical record revealed no evidence of documentation when EMS arrived; no documentation of the time the EMS pronounced the resident's death; no documentation the resident's physician or family were notified of death.

In an interview with the RN night Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that at approximately 4:30AM, he was called to resident #4's room, where Resident #4 was found unresponsive and he immediately began to perform CPR since the resident had full code resuscitation status. The RN night Nurse Manager stated that he instructed a staff member to call 911 and when the EMS arrived, they evaluated Resident #4 and instructed him to stop performing CPR. He stated that while EMS was on site in Resident #4’s room, a roommate, Resident #5, was observed by staff, not to be breathing. The RN night Nurse Manager stated that CPR was not initiated due to Resident #5's "Do Not Resuscitate" (DNR) directive.

e) Review of medical records available for Resident #5 on 09/15/17 indicated the resident was admitted to the facility on 05/09/03 with medical diagnoses including cardiac disease, hypertension, history of head injury, TIA (Transient Ischemic Attack), cellulitis of the abdominal wall, PEG placement, dementia, dysphagia, chronic pain, multiple contracture sites, incontinence of bowel and bladder, aphasia (inability to verbally express oneself) and impaired mobility.

Review of a significant change MDS with an ARD
Continued From page 17 of 05/12/17 documented the resident had severe cognitive impairment and was totally dependent on nursing staff for his mobility and ADLs.

Review of Resident #5's vital signs monitoring indicated on 09/12/17 at 2:20 PM - T 98.6, RR 16, HR 76, and BP 126/72.

Review of available medical record progress notes dated on 09/14/17 at "8:15 as a late entry"-indicated Resident #5 was observed at 11:15 (the time documented did not indicate AM or PM) to be resting in bed with respirations that were even and unlabored. No additional documentation was available for review. As indicated above, Resident #5 was evaluated by EMS after attending to Resident #4 and pronounced dead by EMS (Emergency Medical Service) while on site according to the interview conducted on 09/13/17 at 12:32 PM with the RN night Nurse Manager.

f) Review of medical records available for Resident #6 on 09/15/17 indicated that the resident was admitted to the facility on 02/09/17 with medical diagnoses including hypertension, COPD with exacerbation, bronchitis, asthma, benign prostatic hyperplasia (BPH), history of falls, generalized weakness, functional decline, history of urinary tract infection (UTI), incontinence of bowel and bladder and pressure wounds.

Review of the quarterly MDS with an ARD of 08/16/17 documents the resident scored a 15 out of 15 on the BIMS, indicating no cognitive impairment, with functional status requiring extensive assistance from nursing staff for mobility and ADLs.
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Review of the September 2017 MAR indicated the last documentation on 09/13/17 at 1:42 AM- T 97, HR 69, RR 18, and BP 120/76. Review of progress notes indicated the last entry, dated on 09/04/17, which revealed the resident refused shower and was given a bed bath instead.

In an interview with the RN night Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that at approximately 4:30 AM, staff notified him that Resident # 6, was found to be unresponsive and not breathing. He stated that EMS personnel were already in the facility, and initiated CPR, due to the resident's full code directive status and EMS personnel pronounced the resident death. The nurse stated that the resident had not exhibited any signs of distress prior to death.

g) Review of medical records available for Resident #7 on 09/15/17 indicated that the resident was admitted to the facility on 09/12/15 with medical diagnoses including cerebral infarction with cerebrovascular accident (CVA), aphasia, hypertension, cardiovascular disease, generalized muscle weakness, history of UTI, protein malnutrition, dysphagia and PEG tube placement.

Review of the quarterly MDS with an ARD of 06/18/17 documented the resident had severe cognitive impairment and is totally dependent on nursing staff for mobility and ADLs.

Record review indicated the last vital signs taken on 09/12/17 at 10:34 PM, were documented as T 97, HR 70, RR 16 and BP 122/74. The last nursing note entry was dated on 08/09/17 at 10:53 PM, which indicated the resident was
### Continued From page 19

Review of the hospital clinical record revealed Resident #7 arrived to the hospital ED via EMS on 09/13/17 at 7:03 AM with a chief complaint of shortness of breath. Review of the EMS Initial Patient Assessment form dated 09/13/17 documented their patient contact at the facility was at 6:55 AM. The narrative of events included altered mental status, hyperthermia and respiratory distress. The patient's temperature is documented as 103.3 degrees F and skin temperature as feeling hot.

Review of the ED clinical record revealed documentation by the ED RN dated 09/13/17 at 7:05 AM stating 'Received patient from a nursing facility for fever and unresponsive. Per EMS nursing facility has no air conditioning and patient possible has heat exhaustion. Patient arrived on a non-rebreather with labored shallow respirations. Cardiac monitor applied. Patient is pulseless, CPR initiated.'

Review of the ED clinical record revealed documentation by the ED physician dated 09/13/17 at 7:10 AM states, 'Patient with history of hypertension presents to the ED with SOB onset PTA (prior to arrival). Patient was brought in by EMS from (name of facility). They have not had electricity since Monday due to the hurricane. was brought in with SOB and became unresponsive with asystole on arrival.

Resuscitative efforts were commenced in the ED.

Resident #7's temperature on 09/13/17 at 7:50 AM is documented in the ED record as 42.5 °F.
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<td>degrees C rectally (108.5 degrees F).</td>
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<td>Despite resuscitative efforts, Resident #7 expired at 7:54 AM in the ED.</td>
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<td>h)</td>
<td>Review of medical records available for Resident #8 on 09/15/17 indicated that the resident was admitted to the facility on 11/17/09 with medical diagnoses including heart disease, hypertension, CVA, hemiplegia (paralysis to one side of the body), convulsions, and atrial fibrillation.</td>
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<td>Review of the quarterly MDS with an ARD of 08/15/17 documented a BIMS score of 14 out of 15, which indicated the resident was cognitively intact and she was totally dependent on nursing staff for mobility and ADLs.</td>
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<td>Further review of the record indicated the vital signs on 09/12/17 at 4:16 AM, the resident had a temperature of 102 degrees F and Tylenol 650 mg was administered as ordered. Follow-up vital sign monitoring on 09/12/17 at 2:18 PM indicated T 98.2, RR 16, HR 70, and BP 134/76.</td>
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<td>Review of the progress note dated on 09/13/17 at 3:31 AM, written by the LPN, indicated that Resident #8 was observed to be alert with flushed, clammy skin. Vital sign monitoring revealed - BP 148/76, HR 79, RR 19, T101 degrees F, with 88% oxygen saturation on room air. Oxygen at 2 liters via nasal cannula was administered to the resident with an increase to 96% oxygen saturation. Tylenol was administered as ordered for fever. Further review of the progress note, time stamped on &quot;09/14/17 at 8:05 PM&quot; indicated &quot;late entry&quot; the LPN documented stating at approximately 4:20 AM Resident #8 had</td>
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a change of condition and was observed in respiratory distress. The note further indicated the resident’s respiratory rate was 28 breaths per minute, rapid and labored and oxygen was applied. 911 was called to transfer the resident by EMS to the hospital for evaluation.

Review of the hospital clinical record revealed Resident #8 arrived to the hospital ED via EMS on 09/13/17 at 6:42 AM with a chief complaint of cardiac arrest and severe hyperthermia.

Review of the ED record revealed Resident #8 was pronounced dead at 6:49 AM on 09/13/17.

Review of the ED Vital Signs documentation revealed Resident #8’s temperature taken following death on 09/13/17 at 7:04 AM was 43.3 degrees C (109.9 F) rectally.

Review of the ED physician summary documentation dated 09/13/17 at 7:47 AM states in part, ‘patient who presents to Emergency Department with a chief complaint of cardiac arrest. Patient has a medical history of hypertension, hypothyroidism, seizure disorder, history of stroke is likely bed bound patient arriving from skilled nursing facility. Patient arrives extremely hyperthermic, in asystolic cardiac arrest...pulse check was performed every 3-5 minutes. The patient continued to be in asystolic arrest bedside ultrasound shows no cardiac activity.’

The ED physician further documented on 09/13/17 at 7:47 AM, ‘In summary arriving from a skilled nursing facility in asystolic cardiac arrest very hyperthermic, cold fluids were administered in the emergency
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Department. Patient remained asystolic on the monitor. No cardiac activity was noted on any of the ultrasound checks. No obvious reversible cause to explain asystolic arrest. The patient was pronounced dead by me. Team was in agreement to call code. RN attempting to call family.

On 09/13/17 at 1:30 PM during the interview with the Administrator and DON, the Administrator stated the local law enforcement police chief contacted him at approximately 5:30 AM to inform him they were conducting a mandatory evacuation of the facility due to the excessive temperatures inside the building. The Administrator stated he arrived to the facility around 6:00 AM and he observed residents were evacuated to the outside. The DON stated at this time she too was notified by facility staff around 5:30 AM to inform her the police chief was in the process of evacuating the second floor due to excessive high temperatures and when she arrived all the residents from the second floor had been moved to the first floor or outside with staff. On 09/15/17 at 9:31 AM, a telephone interview was conducted with the DON inquiring if she was able to produce a staffing list for the days post the hurricane. She stated she does not have access to her office as the facility is under lock down by the local police, however she will attempt to compile a list from memory and it may not be all-inclusive.

The hand written nursing staffing list provided by the DON via email on 09/15/17 at 4:37 PM was reviewed. Review of the provided staffing list revealed on Monday September 11, 2017 on the day shift from 7:00 AM to 7:00 PM the number of licensed nursing staff for the first and second floors included 5 Licensed Practical Nurses.
**REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1200 N 35TH AVE
HOLLYWOOD, FL 33021

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
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<td>F 223</td>
<td>Continued From page 23 (LPN), 10 Certified Nursing Assistants (CNA), 1 Registered Nurse (RN) and 2 Minimum Data Set (MDS) licensed nurses. Additionally, the DON was on site in the facility until 1:00 PM to 1:30 PM and the Administrator was on site in the facility until approximately 7:00 PM. Review of the Monday, September 11, 2017 night shift staffing list from 7:00 PM to 7:00 AM the number of licensed nursing staff for the first and second floors included 4 LPN's and 9 CNA's. Review of the Tuesday, September 12, 2017 day shift staffing list from 7:00 AM to 7:00 PM the number of licensed nursing staff for the first and second floors included 5 LPN's, 1 RN, 15 CNA's, 2 wound care LPN's and 1 MDS licensed nurse. Additionally, there was a hospice LPN on site providing continuous comfort care at the bedside of Resident #3. Review of the Tuesday, September 12, 2017 night shift staffing list from 7:00 PM to 7:00 AM the number of licensed nursing staff for the first and second floors included 4 LPN's, 3 RN's, and 5 CNAs. Additionally, there was a hospice LPN who commenced a night shift at 11:30 PM for continuous comfort care at the bedside of Resident #3. Further, the Administrator was on site in the facility until approximately 11:00 PM to 11:30 PM. As discussed with the Administrator during the interview on 09/13/17 at 1:20 PM he confirmed the facility day-to-day functions were not affected by the power failure to the AC unit and the routine dietary and housekeeping services were still being provided.</td>
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**NAME OF PROVIDER OR SUPPLIER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1200 N 35TH AVE
HOLLYWOOD, FL 33021
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<th>(X4) ID PREFIX TAG</th>
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<td>F 223</td>
<td>Continued From page 24 Review of the Florida Department of Children and Families web site reveals an abuse hot line is available 24 hours a day, 7 days a week, which states, &quot;Serves as a central reporting center for allegations of abuse and neglect and/ or exploitation for all children and vulnerable adults in Florida ... .... Persons mandated to report suspected abuse or neglect include Nursing Home staff.&quot;</td>
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<td>F 252 SS=K</td>
<td>483.10(e)(2)(i)(1)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced</td>
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Based on interview and record review, the facility failed to provide a safe and comfortable environment for 8 of 8 sampled residents. Resident #1, #2, #3, #4, #5, #6, #7 and #8 out of 59 residents residing on the second floor of the facility. The facility failed to recognize the potential health risk of the rising internal facility temperatures and humidity, affecting vulnerable elderly residents residing in a facility that experienced a power outage related to Hurricane Irma, a major hurricane. The power outage resulted in the lack of adequate central air conditioning (AC), which exposed the facility residents to increasingly excessive heat. Eight vulnerable residents in the facility developed severe heat-related conditions and consequently died within 6 to 7 hours during the early morning of September 13, 2017. The other facility residents were evacuated to the hospital across the street to protect them from potential serious harm. The facility's failure to provide the necessary actions to maintain a safe and comfortable environment resulted in immediate jeopardy. Cross refer to F223, F309, and F490.

The findings included:

1. Review of the facility 2017 Comprehensive Emergency Management Plan, approved by the Broward County emergency management division on July 21/17, revealed the facility had contractual agreements with another long-term care facility and transportation company for emergency or evacuation purposes. These services were not activated after a major hurricane rendering the facility without air conditioning for approximately 62 hours or
Continued From page 26

approximately 3 days. Additionally, the nursing home is located directly across the street from a large 621 bed public hospital, which did not lose power or air conditioning during or after the hurricane. According to Google Maps, the facility is located 0.2 miles (1056 feet) from front door to front door.

On 09/13/17 at approximately 12:30 PM, an interview was conducted with the facility Director of Engineering who stated at approximately 3:49 PM on 09/10/17 he heard a bang outside and determined a transformer located on a pole across the street had been hit by a tree. He stated at that time he began checking the AC function within various parts of the building. He stated the inside temperature was up to 77 degrees F due to the AC chiller not functioning as a result of the blown transformer. He further stated the malfunctioning line was the dedicated electric line to the facility AC chiller. Additionally he stated the facility has a functioning generator however, it is not hooked up to the central AC unit. He further stated on site they had 10 rented portable AC units and fans and he started to set them up immediately when he determined the central AC malfunctioned and they started to set up 2 in the adjoining behavioral hospital, and in the nursing home they set up 3 on the second floor and 4 on the first floor with one malfunctioning. Additionally he stated he placed fans in each resident room and large industrial fans set up in the hallways.

On 09/25/17 at 4:06 PM, a telephone interview was conducted with a state agency fire protection specialist who reviewed his facility file and determined the approximate square footage on the second floor was 16,000 square feet with 8-9
### Review of the Weather Underground.com website temperature readings from the weather station at the Fort Lauderdale/Hollywood International Airport, located 6 land miles from the facility, indicated for 09/11/17 at 5:53 PM the outside temperature was 89.6 degrees Fahrenheit (F) with a heat index of 96.2 F and humidity of 55%.

On 09/11/17 at 11:55 PM, the outside temperature was 80.6 degrees F with a heat index of 86.2 and humidity of 84%.

On 09/12/17 at 7:53 AM, the outside temperature was 78.8 degrees F with a humidity of 89%.

On 09/12/17 at 12:53 PM, the outside temperature was 87.8 degrees F with a heat index of 95.6 degrees F and humidity of 62%.

On 09/12/17 at 6:53 PM, the outside temperature was 87.8 degrees F with a heat index of 92.6 degrees F and humidity of 55%.

On 09/12/17 at 10:53 PM, the outside temperature was 82.9 degrees F with a heat index of 91.8 degrees F and humidity of 82%.

On 09/13/17 at 1:53 AM, the outside temperature was 82 degrees F with a heat index of 89.4 degrees F with humidity of 82%.

On 09/13/17 at 4:53 AM, the outside temperature was 79 degrees F with 88% humidity.

On 09/13/17 at approximately 12:32 PM, an interview was conducted with the RN night shift
Continued From page 28

Nurse Manager who stated he arrived on duty on 09/12/17 at 7:00 PM and noted portable AC coolers along with numerous fans located throughout the facility.

On 09/13/17 at 1:20 PM, an interview was conducted with the facility Administrator and Director of Nurses (DON). The Administrator stated he was onsite from Friday 09/09/17 around 1:30 PM to 2:00 PM and never left the facility until Monday 09/11/17 around 7:00 PM to 7:30 PM. He stated he had been active on the daily FL Health STAT Database and he had notified the state agency he would not be accepting any new residents due to the AC issues. He stated he left the facility last night (09/12/17) at around 11:00 PM - 11:30 PM and he received no report of resident concerns upon exiting. The DON stated during the interview on 09/13/17 at approximately 1:30 PM she remained in the facility on 09/08/17 through 09/11/17 leaving the facility around 1:30 PM. She stated she had instructed the nurses and aides to monitor the residents frequently and offer water and ice every hour.

On 09/13/17 at approximately 12:32 PM the Registered Nurse (RN) night shift Nurse Manager stated on the 09/13/17 night shift commencing on 7:00 PM, he instructed the 4-5 licensed nurses on duty to monitor residents and provide ice water every hour.

2. Resident #1 was transferred by Emergency Medical Services (EMS) to the hospital on 09/13/17 at 3:24 AM with altered mental status. temperature as recorded in the Emergency Department (ED) was 107 degrees F. sustained cardiac and respiratory arrest. Resident #1 expired in the hospital ED on 09/13/17 at 3:09
Continued From page 29
PM. The final diagnosis was Heat Stroke. The Merriam-Webster Medline Plus Medical Dictionary definition of "heat stroke" is "a life-threatening condition characterized by cessation of sweating with inadequate elimination of body heat, extremely high temperature, rapid pulse, hot dry skin, flaccid muscles, delirium, collapse, and coma and resulting from prolonged exposure to high environmental temperature which causes a dysfunction of the temperature-regulating mechanism of the body".

Review of the ED RN Triage note dated 09/13/17 at 3:29 AM documents, 'Rescue call for code, patient found non-verbal, with tympanic (taken in the ear) temp 107. Per rescue facility does not have AC.'
On 09/13/17 at 7:53 AM an ED physician progress note documented under Assessment/Plan - 'Hyperthermia of 107 degrees Fahrenheit; presumed non-exertional heatstroke since nursing home has been without power since hurricane. Patient received IV fluid and cold water baths and fanning. Temp dropped to 41 C after the treatment and is now 37.8 C.'

3. Resident #2 was transferred by EMS to the hospital on 09/13/17 at 4:32 AM with cardiac and respiratory arrest. temperature as recorded in the ED was 108.3 degrees F. Further review of the ED clinical record revealed documentation dated 09/13/17 at 4:33 AM completed by the ED RN stating 'Resident from (name of nursing home). Nursing staff called 911 for complaints of fever. On arrival patient noted to be in cardiac arrest with CPR (cardiopulmonary resuscitation) in progress. EMS states conditions of facility were untenable due to lack of functioning AC. EMS states they did note fans however they were
4. Resident #3 was admitted to the facility on 06/30/16 and subsequently admitted to hospice services on 10/16/16. Review of the clinical record revealed the last documented physician hospice note in the chart dated 08/01/17 documents 'Resident with history of end stage heart failure, history of hypertension, weakness, and aspiration.' Review of the hospice records dated 09/06/17 documents the resident was exhibiting agitation requiring medications. There is no further documentation regarding the resident's status up to 09/12/17, 2 days after the hurricane, when was assessed by the physician to be experiencing multi system decline including respiratory distress. The resident was subsequently placed on 24-hour hospice bedside nursing care for comfort measures. Review of the facility Vital Signs record revealed the last documented temperature is 97 degrees F dated 09/12/17 at 12:00 AM. Review of the hospice Continuous Care Shift Care Note dated 09/12/17 at 8:00 PM documents the resident's temperature is 99.5 degrees F with a respiratory rate of 36. Further review of the note documents at 9:00 PM the resident's temperature is 102.5 degrees F. Resident #3 was administered Tylenol at 9:00 PM on 09/12/17. On 09/12/17 at 10:00 PM, Resident #3's temperature was 102 degrees F with a heart rate of 115 and respiratory rate of 42. Review of the Continuous Care Shift Care Note the hospice Licensed Practical Nurse documented at 10:00 PM 'SOB (shortness of breath), head of bed up to facilitate ease of breathing; cool room with fan to facilitate of the air circulation of the room maintained.'
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<th>(X4) ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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| F 252           | Continued From page 31 Resident #3 expired on 9/13/17 at 1:35 AM with the hospice nurse at bedside. 5. Resident #4 was found in room on 9/13/17 at approximately 4:30 AM in cardiac arrest. 911 was called. EMS pronounced the resident expired in the facility. 6. Resident #5 was discovered deceased in room on 9/13/17 at approximately 4:30 AM. was pronounced deceased by EMS while they were on site. 7. Resident #6 was discovered in room unresponsive and not breathing on 9/13/17 at approximately 4:30 AM. EMS personnel were on site and initiated CPR. CPR was not successful and EMS pronounced Resident #6 deceased. 8. Resident #7's was transferred by EMS to the hospital on 9/13/17 at 7:03 AM with cardiac and respiratory distress. temperature as recorded in the ED at 7:50 AM was 108.5 degrees F. Review of resident #7's ED clinical record revealed documentation by the ED RN dated 09/13/17 at 7:05 AM stating 'Received patient from a nursing facility for fever and unresponsive. Per EMS nursing facility has no air conditioning and patient possible has heat exhaustion. Patient arrived on a non-rebreather with labored shallow respirations. Cardiac monitor applied. Patient is pulseless, CPR initiated.' Review of the ED clinical record revealed documentation by the ED physician dated 09/13/17 at 7:10 AM states, 'Patient with history of hypertension presents to the ED with SOB onset PTA (prior to arrival). Patient was brought in by EMS from (name of facility). They have not
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC**

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| F 252 | | Continued From page 32 had electricity since Monday due to the hurricane. was brought in with SOB and became unresponsive with asystole (flat line cardiac rhythm) on arrival. Resident #7 expired in the hospital ED on 09/13/17 at 7:54 AM. 9. Resident #8 was transferred by EMS to the hospital on 09/13/17 at 6:42 AM with cardiac arrest and severe hyperthermia. Resident #8 was pronounced deceased at 6:49 AM. temperature recorded in the ED at 7:04 AM, following death, was 109.9 degrees F. 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**A. BUILDING __________________________________**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 105021

**B. WING ________________________________**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED: 09/22/2017**

**NAME OF PROVIDER OR SUPPLIER: REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC**

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1200 N 35TH AVE, HOLLYWOOD, FL 33021

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OBS NO. 0938-0391**

**105021 printed: 10/13/2017**

**FORM APPROVED: 10/13/2017**

**OMB NO. 0938-0391**

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<td>F 309</td>
<td>Continued From page 33 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.</td>
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<td>(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on interview and record review, the facility failed to ensure that 7 of 8 medically fragile residents, out of a total of 59 residents residing on the second floor, receive treatment and care in accordance with professional standards of practice. These 7 residents were Residents #1, #2, #4, #5, #6, #7, and #8.</td>
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<td>The facility’s central air conditioning system became inoperable from the afternoon of September 10, 2017 through the early morning of September 13, 2017, after Hurricane Irma occurred. The facility residents were exposed to increasingly excessive heat, which caused the 7 affected residents to have serious heat-related conditions and these residents consequently died. The other facility residents were evacuated to the hospital across the street to protect them from potential serious harm. The facility’s failure to provide the necessary care and services to protect the facility resident’s health resulted in immediate jeopardy. Cross refer to F223, F309, and F490.</td>
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<td>The findings included:</td>
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<td>1. On 09/13/17 at approximately 12:30 PM, an</td>
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### F 309

Continued From page 34

Interview was conducted with the facility Director of Engineering who stated at approximately 3:49 PM on 09/10/17 he heard a bang outside and determined a transformer located on a pole across the street had been hit by a tree. He stated at that time he began checking the AC (air conditioner) function within various parts of the building. He stated the inside temperature was up to 77 degrees due to the AC chiller not functioning as a result of the blown transformer. He further stated the malfunctioning line was the dedicated electric line to the facility AC chiller. Additionally he stated the facility never lost power during the storm and as a result, the generator was not needed.

2. Review of medical records available for Resident #1 on 09/15/17 indicated Resident #1 was admitted to the facility on 09/28/15 with medical diagnoses including Chronic Obstructive Pulmonary Disease (COPD), heart failure, hypertension, atrial fibrillation, diabetes and dyspnea (difficulty breathing).

Review of the Federally required comprehensive resident assessment, referred to as the MDS (Minimum Data Set) quarterly assessment with an Assessment Reference Date (ARD) of 04/07/17 documents under Cognitive Pattern the resident scored a 15 out of 15 on the BIMS (brief interview of mental status) scale and Functional Status is documented as extensive assistance for mobility and ADLs (activities of daily living).

Further review of the medical record indicated that Resident #1’s vital signs were being monitored. Review of the September 2017 Medication Administration Record (MAR), 'last entry' dated 09/11/17 at 11:53 PM indicated
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Temperature (T) 97, Heart Rate (HR) 80, Respiratory Rate (RR) 19 and Blood Pressure (BP) 130/72 mmHg at 6:37AM.
Reference ranges for a normal adult vital signs obtained from the National Institute of Health/U.S. National Library of Medicine are as follows: Temperature 97.8 to 99.1 F; Heart Rate 60-100 beats per minute; Respiratory Rate 12-18 breaths per minute; Blood Pressure 90/60 to 120/80 millimeter of mercury.

The September 2017 MAR indicated that the resident was prescribed and receiving oxygen 2 liters per minute continuously via nasal cannula and ordered fluid restrictions for a total of 900 ml (milliliters) every shift, 600 ml dietary/300 ml nursing.

Review of the available facility nursing progress note dated on 09/14/17 at 7:43 PM, indicated as a 'late entry' by a Registered Nurse (RN) that she reported to duty at 7 PM and observed Resident #1 sitting up in bed in the hallway by the nurses station and had oxygen being administered continuously. The note indicated the resident was in stable condition, with no signs of respiratory distress, was afebrile (no fever) and respirations were even and unlabored. The nurse documented that the resident's vital signs were stable and fluids were offered and tolerated well.

Review of available nursing progress note dated 09/13/17 at 5:01 AM by the RN night shift Nurse Manager indicated that Resident #1 was observed to be in respiratory distress. The resident's vital signs indicated BP 128/68, and 80% oxygen saturation rate on room air with 15 liters via non-breather, which improved to 92% oxygen saturation. 911 was called and the
F 309 Continued From page 36

resident was transferred via Emergency Medical Services (EMS) to the hospital for evaluation. According to MayoClinic.org website, normal pulse oximeter readings for oxygen saturation rates usually range from 95 to 100 percent. Values under 90 percent are considered low.

In an interview with the RN night shift Nurse Manager on 09/13/2017 starting at 12:32 PM, he stated he began his shift on 09/12/17 at 7 PM and had received report that "all residents were stable and everything was under control." He stated that he had instructed the nurses on duty to monitor all the residents and provide ice water every 1 hour. He recalled around 1:30 AM, he was called to resident #1's room, where Resident #1 was observed in respiratory distress. He stated the resident's lips were bluish in color and after he assessed did not require CPR (cardiopulmonary resuscitation). He stated that he applied additional oxygen and the resident's vital signs were stable. He stated that 911 was called and Resident #1 was transferred by EMS to the hospital for evaluation. He stated that Resident #1 was alive and breathing on transfer.

Review of the hospital clinical record revealed Resident #1 arrived to the hospital Emergency Department (ED) via EMS on 09/13/17 at 3:24 AM with a chief complaint of altered mental status.

Review of the ED Registered Nurse (RN) Triage note dated 09/13/17 at 3:29 AM documents, 'Rescue call for code, patient found non-verbal, with tympanic (taken in the ear) temp 107. Per rescue facility does not have AC (air conditioning).'
Review of the ED clinical record revealed initial vital signs documented on 09/13/17 at 3:30 AM by the ED RN to include a temperature of 40.7 degrees Celsius (C) (105.3 Fahrenheit (F) via axillary route (under arm pit). Resident #1's BP is documented as 100/57; HR 150; RR 27. Emergent treatment was commenced on arrival to the ED.

Further review of the ED clinical record revealed Resident #1 deteriorated rapidly and required emergent endotracheal tube intubation and mechanical ventilation for acute respiratory failure on 09/13/17 at 3:39 AM.

On 09/13/17 at 3:43 AM, Resident #1's core temperature is documented as 41.7 degrees C. (107.1 F).

On 09/13/17 at 4:20 AM, Resident #1's core temperature is documented as 41 degrees C. (105.8 degrees F).

Review of documentation by the ED RN dated 09/13/17 at 4:30 AM states Resident #1 'Received 5 liters of cold normal saline and ice packs were applied to underarms, and posterior neck and the temperature in the room was decreased to 55 degrees F.'

Further review of the ED clinical record dated 09/13/17 at 7:30 AM, revealed Resident #1's BP was dropping necessitating the initiation of an intravenous Dopamine drip to sustain blood pressure and subsequently intravenous Levophed, an additional medication to sustain blood pressure.

On 09/13/17 at 7:53 AM an ED physician
Continued From page 38

progress note documented under Assessment/Plan - 'Hyperthermia of 107 degrees Fahrenheit; presumed non-exertional heatstroke since nursing home has been without power since hurricane. Patient received IV fluid and cold water baths and fanning. Temp dropped to 41 C after the treatment and is now 37.8 C.'

On 09/13/17 at 8:15 AM, the residents' health care surrogate made the decision to withdraw any further life support measures.

On 09/13/17 at 9:10 AM, an intravenous Morphine drip was commenced.

On 09/13/17 at 9:22 AM, the mechanical ventilation was discontinued and the oral endotracheal tube was removed.

On 09/13/17 at 3:09 PM Resident #1 was pronounced by the physician; patient pulseless with no respirations.

The Clinical Impression as documented in the clinical record by the ED physician after initial assessment on 09/13/17 at 3:34 AM, states under Diagnosis, 'Heat stroke.' The Merriam-Webster Medline Plus Medical Dictionary definition "heat stroke" is "a life-threatening condition characterized by cessation of sweating with inadequate elimination of body heat, extremely high temperature, rapid pulse, hot dry skin, flaccid muscles, delirium, collapse, and coma and resulting from prolonged exposure to high environmental temperature which causes a dysfunction of the temperature-regulating mechanism of the body".

3. Review of medical records available for
F 309 Continued From page 39
Resident #2 on 09/15/17 indicated the resident was admitted to the facility on 06/26/17 with medical diagnoses including peripheral vascular disease (PVD), history of transient ischemic attack (TIA), cough, dementia, dysphagia (difficulty swallowing), history of pneumonia status post aspiration, and percutaneous endoscopic gastrostomy (PEG) placement for nutritional and hydration needs.

Review of the quarterly MDS with an ARD of 05/04/17 documents the resident has severe cognitive impairment and was totally dependent for mobility and ADLs.

Further review of the record indicated that on 09/12/17 at 7:11 PM, Resident #2 was assessed with no respiratory distress, but had an axillary (under armpit) temperature of 99.8 degrees F. The RN notified the health care provider and administered Tylenol 325 milligrams via the PEG tube. A follow-up temperature indicated a decrease in temperature to 98.8 degrees F.

Further review of the record indicated no additional temperature monitoring conducted. Review of the progress note dated on 09/13/17 at 4:42 AM indicated the RN observed Resident #2 to have shortness of breath (SOB) and positive breath sounds for rhonchi. The note indicated the RN suctioned the resident twice and vital signs were taken, BP 126/78, HR 104, RR 24, labored, and T 101.6 degrees F. The resident was assessed to have 77% oxygen saturation on room air and oxygen was applied. 911 was called and Resident #2 was transferred by EMS to the hospital for evaluation.

In an interview with the RN night shift Nurse Manager on 09/13/17 starting at 12:32 PM, he
Continued From page 40

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stated that he recalled that earlier in the evening, he had observed Resident #2 in the 2nd floor hallway, near a portable air conditioner (AC) cooler. He stated that at approximately 2:30AM on 09/13/2017, he was called by staff to the Resident #2's room, observed in respiratory distress, and foaming at the mouth. He stated that he suctioned the resident's mouth and told a staff to call 911 for EMS transfer to the hospital for evaluation.

Review of the hospital clinical record revealed Resident #2 arrived to the hospital ED via EMS on 09/13/17 at 4:32 AM with a chief complaint of cardiac arrest.

Review of the ED clinical record dated 09/13/17 at 4:34 AM completed by the ED physician documents 'Patient presents to ED via EMS from nursing home as a code heart today. Per EMS the patient was found to have a temp of 107 on scene.'

Review of the hospital Vital Signs log documents the initial temperature taken on 09/13/17 at 4:33 AM was 42.4 C. (108.3 F.). Resident #2 did not have a recordable pulse or blood pressure.

Further review of the ED clinical record revealed documentation dated 09/13/17 at 4:33 AM completed by the ED RN stating 'Resident from (name of nursing home). Nursing staff called 911 for complaints of fever. On arrival patient noted to be in cardiac arrest with CPR in progress. EMS states conditions of facility were untenable due to lack of functioning AC. EMS states they did note fans however they were inadequate in relationship to patient's location whereabouts.'
Continued From page 41

Review of the ED Course documentation by the ED physician dated 09/13/17 commencing at 4:34 AM and continuing to 5:00 AM, documents ‘Per rescue patient was hyperthermic (an increased temperature in the body), (confirmed in the ED) with asystolic (flat line heart rhythm) arrest. ACLS (advanced cardiac life support) initiated in the field and continued in the ED. No sustained rhythm despite ACLS. Patient pronounced.’

Despite resuscitative efforts in the ED, Resident #2 was pronounced dead at 5:00 AM on 09/13/17.

4. Resident #4 was admitted to the nursing home on 10/17/15 with diagnoses to include dementia, hypertension, congestive heart failure, peripheral vascular disease, right above knee amputation, anemia, and atherosclerotic heart disease. Resident #4 had ‘Full Code’ cardiac resuscitation directives.

Review of the quarterly MDS with an ARD of 04/19/17 documents the resident scored a 6 out of 15 on the BIMS, indicating severe cognitive impairment with functional status requiring extensive assistance for mobility and ADLs.

Review of the facility Vital Signs record dated 09/13/17 at 1:28 AM documents the resident’s T at 97 degrees F; HR of 74 and RR of 18, and at 1:29 AM, the resident’s blood pressure is documented as 128/74. There are no further vital signs or temperatures documented in the clinical record reviewed.

Review of Resident #4’s clinical record revealed a Nursing Progress Note dated 09/14/17 at 7:42 PM the Licensed Practical Nurse (LPN)
Continued From page 42

documented, 'Late entry: Patient received at 11:15 PM (no date documented) resting in bed, no distress noted. Respiration even and non-laborated. Blood pressure within normal limits, afebrile. Remain in stable condition.'

The next entry in the Nursing Progress Notes dated 09/14/17 at 7:54 PM by the LPN documented, 'Late entry: approximately 4:00 AM patient noted cardiac arrest with shallow breathing. BP 90/56, RR 15, HR 52. Non-rebreather applied, heart rate ceased. CPR initiated. 911 called. Rescue arrived pronounced resident death.'

Further review of Resident #4's clinical record revealed no evidence of documentation when EMS arrived; no documentation of the time the EMS pronounced the resident's death; no documentation the resident's physician or family were notified of death.

In an interview with the RN night Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that at approximately 4:30AM, he was called to Resident #4's room, where Resident #4 was found unresponsive and he immediately began to perform CPR since the resident had full code resuscitation status. The RN night Nurse Manager stated that he instructed a staff member to call 911 and when the EMS arrived, they evaluated Resident #4 and instructed him to stop performing CPR. He stated that while EMS was on site in Resident #4's room, a roommate, Resident #5 was observed by staff, not to be breathing. The RN night Nurse Manager stated that CPR was not initiated, due to Resident #5's "Do Not Resuscitate" (DNR) directive.
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<td>F 309</td>
<td>Continued From page 43 5. Review of medical records available for Resident #5 on 09/15/17 indicated the resident was admitted to the facility on 05/09/03 with medical diagnoses including cardiac disease, hypertension, history of head injury, TIA (Transient Ischemic Attacks), cellulitis of the abdominal wall, PEG placement, dementia, dysphagia, chronic pain, multiple contracture sites, incontinence of bowel and bladder, aphasia (inability to verbally express oneself) and impaired mobility. Review of a significant change MDS with an ARD of 05/12/17 documented the resident has severe cognitive impairment and was totally dependent for mobility and ADLs. Review of Resident #5's vital signs monitoring indicated on 09/12/17 at 2:20 PM- T 98.6, RR 16, HR 76, and BP 126/72. Review of available medical record progress notes dated on 09/14/17 at &quot;8:15 as a late entry&quot;-indicated Resident #5 was observed at 11:15 (the time documented did not indicate AM or PM) to be resting in bed with respirations that were even and unlabored. No additional documentation was available for review. As indicated above, Resident #5 was evaluated by EMS after attending to Resident #4 and pronounced dead by EMS while on site according to the interview conducted on 09/13/17 at 12:32 PM with the RN night Nurse Manager. 6. Review of medical records available for Resident #6 on 09/15/17 indicated that the resident was admitted to the facility on 02/09/17 with medical diagnoses including hypertension, COPD with exacerbation, bronchitis, asthma,</td>
<td>F 309</td>
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<td>09/22/2017</td>
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5021
F 309 Continued From page 44 benign prostatic hyperplasia (BPH), history of falls, generalized weakness, functional decline, history of urinary tract infection (UTI), incontinence of bowel and bladder and pressure wounds.

Review of the quarterly MDS with an ARD 08/16/17 documented the resident scored a 15 out of 15 on the BIMS indicating no cognitive impairment with functional status requiring extensive assistance for mobility and ADLs.

Review of the September 2017 MAR indicated the last documentation on 09/13/17 at 1:42 AM- T 97, HR 69, RR18, and BP 120/76. Review of progress notes indicated the last entry, dated on 09/04/17, which revealed the resident refused shower and was given a bed bath instead.

In an interview with the RN night Nurse Manager on 09/13/17 starting at 12:32 PM, he stated that he recalled that at approximately 4:30 AM, staff notified him that Resident # 6, was found to be unresponsive and not breathing. He stated that EMS personnel were already in the facility, and initiated CPR, due to the resident's full code directive status and EMS personnel pronounced the resident death. The nurse stated that the resident had not exhibited any signs of distress prior to death.

7. Review of medical records available for Resident #7 on 09/15/17 indicated that the resident was admitted to the facility on 09/12/15 with medical diagnoses including cerebral infarction with cerebrovascular accident (CVA), aphasia, hypertension, cardiovascular disease, generalized muscle weakness, history of UTI, protein malnutrition, dysphagia and PEG tube
Continued From page 45 placement.

Review of the quarterly MDS with an ARD of 06/18/17 documented the resident has severe cognitive impairment and was totally dependent for mobility and ADLs.

Record review indicated the last vital signs taken on 09/12/17 at 10:34 PM, were documented as T 97, HR 70, RR 16 and BP 122/74. The last nursing note entry was dated on 08/09/17 at 10:53 PM, which indicated the resident was stable.

Review of the hospital clinical record revealed resident #7 arrived to the hospital ED via EMS on 09/13/17 at 7:03 AM with a chief complaint of shortness of breath.

Review of the EMS Initial Patient Assessment form dated 09/13/17 documented their patient contact at the facility was at 6:55 AM. The narrative of events included altered mental status, hyperthermia and respiratory distress. The patient's temperature is documented as 103.3 degrees F and skin temperature as feeling hot.

Review of the ED clinical record revealed documentation by the ED RN dated 09/13/17 at 7:05 AM stating, "Received patient from a nursing facility for fever and unresponsive. Per EMS nursing facility has no air conditioning and patient possible has heat exhaustion. Patient arrived on a non-rebreather with labored shallow respirations. Cardiac monitor applied. Patient is pulseless, CPR initiated."

Review of the ED clinical record revealed documentation by the ED physician dated
F 309 Continued From page 46

09/13/17 at 7:10 AM states, 'Patient with history of hypertension presents to the ED with SOB (shortness of breath) onset PTA (prior to arrival). Patient was brought in by EMS from (name of facility). They have not had electricity since Monday due to the hurricane. was brought in with SOB and became unresponsive with asystole on arrival.

Resuscitative efforts were commenced in the ED.

Resident #7’s temperature on 09/13/17 at 7:50 AM is documented in the ED record as 42.5 degrees C rectally (108.5 degrees F).

Despite resuscitative efforts, Resident #7 expired at 7:54 AM in the ED.

8. Review of medical records available for Resident #8 on 09/15/17 indicated that the resident was admitted to the facility on 11/17/09 with medical diagnoses including heart disease, hypertension, CVA, hemiplegia (paralysis to one side of the body), convulsions, and atrial fibrillation.

Review of the quarterly MDS with an ARD of 08/15/17 documents a BIMS score of 14 out of 15, which indicated the resident was cognitively intact and was totally dependent for mobility and ADLs.

Further review of the record indicated the vital signs on 09/12/17 at 4:16 AM, the resident had a temperature of 102 degrees F and Tylenol 650 mg was administered as ordered. Follow-up vital sign monitoring on 09/12/17 at 2:18 PM indicated - T 98.2, RR 16, HR 70, and BP 134/76.
### F 309 Continued From page 47

Review of the progress note dated on 09/13/17 at 3:31 AM, written by the LPN, indicated that Resident #8 was observed to be alert with flushed, clammy skin. Vital sign monitoring revealed - BP 148/76, HR 79, RR 19, T101 F, with 88% oxygen saturation on room air. Oxygen at 2 liters via nasal cannula was administered to the resident with an increase to 96% oxygen saturation. Tylenol was administered as ordered for fever. Further review of the progress note, time stamped on "09/14/17 at 8:05 PM" indicated "late entry" the LPN documented stating at approximately 4:20 AM resident #8 had a change of condition and was observed in respiratory distress. The note further indicated the resident's respiratory rate was 28 breaths/minute, rapid and labored and oxygen was applied. 911 was called to transfer the resident by EMS to the hospital for evaluation.

Review of the hospital clinical record revealed Resident #8 arrived to the hospital ED via EMS on 09/13/17 at 6:42 AM with a chief complaint of cardiac arrest and severe hyperthermia.

Review of the ED record revealed Resident #8 was pronounced dead at 6:49 AM on 09/13/17.

Review of the ED Vital Signs documentation revealed Resident #8's temperature taken following death on 09/13/17 at 7:04 AM was 43.3 degrees C (109.9 F) rectally.

Review of the ED physician summary documentation dated 09/13/17 at 7:47 AM states in part, patient who presents to Emergency Department with a chief complaint of cardiac arrest. Patient has a medical history of hypertension, hypothyroidism, seizure disorder,
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 48</td>
<td>history of stroke is likely bed bound patient arriving from skilled nursing facility. Patient arrives extremely hyperthermic, in asystolic cardiac arrest ...pulse check was performed every 3-5 minutes. The patient continued to be in asystolic arrest bedside ultrasound shows no cardiac activity.</td>
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</tbody>
</table>
| F 490 | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING | 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Nursing Home Administrator failed to use the facility resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 141 residents residing in the facility before and after Hurricane Irma, a major hurricane, occurred. The facility's central air conditioning system became...
### F 490
Continued From page 49

Inoperable from the afternoon of September 10, 2017 through the early morning of September 13, 2017. Seven of 8 medically fragile residents (Residents #1, #2, #4, #5, #6, #7, and #8), out of a total of 59 residents residing on the second floor, were exposed to increasingly excessive heat, which caused the 7 affected residents to have serious heat-related conditions and these residents consequently died. The other facility residents were evacuated to the hospital across the street to protect them from potential serious harm. The Nursing Home Administrator failure to manage the resources to protect the facility residents' health resulted in immediate jeopardy. Cross refer to F223, F252, and F309.

The findings included:

1. Review of the facility 2017 Emergency Management Plan revealed the facility had contractual agreements with another long-term care facility and transportation company for emergency or evacuation purposes. These services were not activated after a major hurricane rendering the facility without air conditioning (AC) for approximately 62 hours or approximately 3 days. Additionally, the nursing home is located directly across the street from a large 621 bed public hospital, which did not lose power or AC during or after the hurricane.

   According to Google Maps, the facility is located 0.2 miles (1056 feet) from front door to front door.

2. On 09/13/17 at 12:05 PM, an interview was conducted with the facility Director of Engineering who stated he was responsible for the engineering of the entire building. He stated on Sunday 09/10/17 at 3:49 PM he heard a bang and determined that a transformer located across...
Continued From page 50
the street had blown. He stated that at that time
he began checking the AC function within various
parts of the building. He stated the inside
temperature was up to 77 degrees Fahrenheit (F)
on 09/10/17 due to the AC chiller not functioning
as a result of the blown transformer. He
explained the malfunctioning line was the
dedicated electric line to the facility AC chiller,
however the building never lost electric power as
it was supplied by a separate line. He stated that
he placed rented portable cooling units
throughout the facility located on the first and
second floors. He stated that he called the power
company 2 times on Sunday 09/10/17.
Additionally he stated the Administrator from the
behavioral health hospital housed in the same
building and the facility Administrator had made
numerous calls to the power company emergency
line expressing the urgent need to come repair
the line.

3. Review of the Florida Governor Rick Scott's
released timeline dated September 19, 2017
documented:
"On Sunday, September 10, 2017 at 6:46 PM, the
(name of facility) was again notified by the state
to report updates to the FL Health STAT
Database on post-storm Hurricane Irma
response. The facility was asked to provide
updates to the database at least twice a day.
However if significant changes occurred, they
would have to report additional updates. All ALFs,
nursing homes and hospitals were asked to
comply.

On Sunday, September 10, 217 at 6:51 PM, the
(name of nursing home) reported through the FL
Health STAT Database that they were closed but
that everything was operational, including heating
"On Monday, September 11, 2017 at 7:30 AM, the (name of facility) previously provided update was counted as their current status in the FL Health STAT Database since they did not report any changes. Per this report, everything remained operational at the (name of facility)."

"On Monday, September 11, 2017 at 5:37 PM, the (name of facility) called the Florida Emergency Information Line, a toll-free hotline activated at the time of an emergency to provide an additional resource for those in Florida to receive accurate and up-to-date information. This line is an information only line for Floridians and is not meant to replace 911."

"On Tuesday, September 12, 2017 at 1:30 PM, the (name of facility) previously provided update was counted as their current status in the FL Health STAT Database since they did not report any changes."

"On Tuesday, September 12, 2017 at 2:00 PM, as part of all impacted counties daily submissions, Broward County submitted a situation report to the state Division of Emergency Management that included an update on all health and medical aspects of storm response in Broward County. Included in this report was a note that the (name of facility) is running on generator power without air conditioning, which is adversely affecting patients, and that a ticket had been put into the power company to ensure priority status."

"On Tuesday, September 12, 2017 at 4:17 PM, a state representative returned the call left on the Governor's personal cell phone by contacting
<table>
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<th>(X5) COMPLETION DATE</th>
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</table>
| F 490               | Continued From page 52 (facility Administrator). The Administrator reported that the (name of facility) was open, that the chiller was not operational pulling outside air but that they had spot coolers and fans, and that power was partial. The Administrator did not, at any time during the call, report or indicate that conditions had become dangerous or that the health and safety of their patients was at risk. State representative advised Administrator to call 911 if there was any reason to believe that the health or safety of patients was at risk."

The timeline indicated the AC power went out on 09/10/17 at approximately 3:49 PM and as of 09/12/17 at 4:17 PM the facility was still without functioning central air conditioning for approximately 47 consecutive hours. The Administrator did not report or indicate any conditions that had become dangerous or pose a risk to the residents and as of 09/13/17 at approximately 3:00 AM, per the timeline; the first patient was taken emergently to the hospital from the facility in critical condition.

4. Review of the Weather Underground.com website temperature readings from the weather station at the Fort Lauderdale/Hollywood International Airport, located 6 land miles from the facility, indicated for 09/11/17 at 5:53 PM the outside temperature was 89.6 degrees F with a heat index of 96.2 F and humidity of 55%.

On 09/11/17 at 11:55 PM, the outside temperature was 80.6 degrees F with a heat index of 86.2 F and humidity of 84%.

On 09/12/17 at 7:53 AM, the outside temperature was 78.8 degrees F with a humidity of 89%.
Continued From page 53

On 09/12/17 at 12:53 PM, the outside temperature was 87.8 degrees F with a heat index of 95.6 degrees F and humidity of 62%.

On 09/12/17 at 6:53 PM, the outside temperature was 87.8 degrees F with a heat index of 92.6 degrees F and humidity of 55%.

On 09/12/17 at 10:53 PM, the outside temperature was 82.9 degrees F with a heat index of 91.8 degrees F and humidity of 82%.

On 09/13/17 at 1:53 AM, the outside temperature was 82 degrees F with a heat index of 89.4 degrees F with humidity of 82%.

On 09/13/17 at 4:53 AM, the outside temperature was 79 degrees F with 88% humidity.

5. On 09/13/17 at 1:20 PM, an interview was conducted with the facility Administrator and Director of Nurses (DON). The Administrator stated he was onsite from Friday 09/08/17 around 1:30 PM to 2:00 PM and never left the facility until Monday 09/11/17 around 7:00 PM to 7:30 PM. He stated he had been active on the daily Florida Health STAT Database and he had notified the state agency he would not be accepting any new residents due to the AC issues. He stated he left the facility last night (09/12/17) at around 11:00 PM - 11:30 PM and he received no report of resident concerns upon exiting.

The DON stated during the interview on 09/13/17 at approximately 1:30 PM she remained in the facility on 09/08/17 through 09/11/17 leaving the facility around 1:30 PM. She stated she had instructed the nurses and aides to monitor the residents frequently and offer water and ice every
### 6. a) Resident #1 was transferred by EMS (Emergency Medical Services) to the hospital on 09/13/17 at 3:24 AM with altered mental status.

- temperature as recorded in the Emergency Department (ED) was 107 degrees F.
- sustained cardiac and respiratory arrest. Resident #1 expired in the hospital ED on 09/13/17 at 3:09 PM. The final diagnosis was Heat Stroke. The Merriam-Webster Medline Plus Medical Dictionary definition of 'heat stroke' as "a life-threatening condition characterized by cessation of sweating with inadequate elimination of body heat, extremely high temperature, rapid pulse, hot dry skin, flaccid muscles, delirium, collapse, and coma and resulting from prolonged exposure to high environmental temperature which causes a dysfunction of the temperature-regulating mechanism of the body".

### b) Resident #2 was transferred by EMS to the hospital on 09/13/17 at 4:32 AM with cardiac and respiratory arrest. temperature as recorded in the ED was 108.3 degrees F. Resident #2 expired in the hospital ED on 09/13/17 at 5:00 AM.

c) Resident #4 was found in room on 09/13/17 at approximately 4:30 AM in cardiac arrest. 911 was called. EMS pronounced the resident expired in the facility.

d) Resident #5 was discovered deceased in room on 09/13/17 at approximately 4:30 AM. was pronounced deceased by EMS while they were on site.

e) Resident #6 was discovered in room
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 490</td>
<td>Continued From page 55 unresponsive and not breathing on 09/13/17 at approximately 4:30 AM. EMS personnel were on site and initiated CPR. CPR was not successful and EMS pronounced Resident #6 deceased. f) Resident #7 was transferred by EMS to the hospital on 09/13/17 at 7:03 AM with cardiac and respiratory distress. Temperature as recorded in the ED at 7:50 AM was 108.5 degrees F. Resident #7 expired in the hospital ED on 09/13/17 at 7:54 AM. g) Resident #8 was transferred by EMS to the hospital on 09/13/17 at 6:42 AM with cardiac arrest and severe hyperthermia. Resident #8 was pronounced expired at 6:49 AM. Temperature recorded in the ED at 7:04 AM, following death, was 109.9 degrees F.</td>
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**Resident #7**
- Transferred by EMS to the hospital on 09/13/17.
- Cardiac and respiratory distress.
- Temperature recorded in the ED at 7:50 AM was 108.5 degrees F.
- Expired in the hospital ED on 09/13/17.

**Resident #8**
- Transferred by EMS to the hospital on 09/13/17.
- Cardiac arrest and severe hyperthermia.
- Pronounced expired at 6:49 AM.
- Temperature recorded in the ED at 7:04 AM, following death, was 109.9 degrees F.