

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11911315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/24/2021</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**CRESCENT WOOD**

**1800 HARRISON STREET  
TITUSVILLE, FL 32780**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| {A 000}                  | Initial Comments<br><br>A second revisit to Complaint Investigation 2021002247 was conducted at Crescent Wood on . The facility had an uncorrected deficiency at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {A 000}             |                                                                                                                          |                          |
| {A 054}<br>SS=D          | 59A-36.008(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use.<br>(b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include:<br>1. The name of the resident and any known ... the resident may have;<br>2. The name of the resident's health care provider and the health care provider's telephone number;<br>3. The name, strength, and directions for use of each medication; and,<br>4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.<br>(c) For medications that serve as chemical ..., the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. | {A 054}             |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |  |                                                                    |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11911315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/24/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRESCENT WOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1800 HARRISON STREET<br/>TITUSVILLE, FL 32780</b>                            |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 054}                                                  | <p>Continued From page 1</p> <p>This Statute or Rule is not met as evidenced by:<br/><b>DEFICIENCY REMAINED UNCORRECTED</b></p> <p>Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) for 2 of 4 sampled residents was properly updated (#6 &amp; #17).</p> <p>Findings:</p> <p>1. Review of the resident #6's count sheet for 5/17/21. #3 revealed documentation that indicated the resident was given the medication twice on 5/17/21 and once on 5/18/21. However, review of the resident's 5/17/21 MOR revealed it did not contain documentation to indicate the resident was given the medication twice on 5/17/21 and once on 5/18/21.</p> <p>2. Review of resident #17's count sheet for 5/17/21. 0.5 milligrams revealed documentation that indicated the resident was given the medication on 5/17/21 and 5/18/21. However, review of the resident's 5/17/21 MOR revealed it did not contain documentation to indicate the resident was given the medication on those dates.</p> <p>At 1:14 p.m. on 5/18/21 the administrator confirmed the findings.</p> <p>Class III</p> | {A 054}                                                                        |                                                                                                                          |  |                                                                    |