Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965581	A. BUILDING: _____ B. WING _____	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST MANOR	504 THIRD AVENUE SOUTH LAKE WORTH, FL 33460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint (#2022011265) survey was conducted on . . . . . through at Crest Manor. The facility had deficiencies identified unrelated to the complaint at the time of the survey.	A 000		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be	A 077		

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A 077	Continued From page 1 under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:	A 077		

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A 077	Continued From page 2 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . . . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, ... , which is incorporated by reference and available online at:	A 077		

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A 077	Continued From page 3 http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility administrator failed to supervise and manage its direct care staff members to exercise their responsibilities to properly document observations for 1 out of 18 sampled residents (Resident #16). The findings are: Review of the facility caregiver/home health aide general duties and job description indicated that each caregiver must maintain "correct and confidential records on residents" and fill "out incident reports as necessary." (Photographic evidence was obtained). Review of the emergency medical services ( ) report dated on at 3:00am indicated that resident #16's was found unresponsive lying on ground. Review of the report indicated that the resident was pulseless and with lividity to his and upper . Further review of this report indicated that the resident was found on the scene due to a , the resident was not transported and the scene was turned to the facility staff on at 3:08am. (Photographic evidence was obtained). Review of resident #16's progress notes dated on at an unspecified time, indicated that his roommate, resident #9, heard a thump inside their room and saw resident #16 on the floor. Review of these progress notes indicated that resident #9 went downstairs to notify "staff ( )	A 077		

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A 077	Continued From page 4 check for a , and immediately started . 911 was called." Further review of these progress notes indicated that "at around 2:30am resident #16 was pronounced ." (Photographic evidence was obtained). Review of resident #16's record indicated that he was admitted to the facility on and he received a medical examination on . Review of the resident's medical examination indicated that the resident was diagnosed with pre- , , , , , , and , . Further review of this medical examination indicated that the resident was independent with all of his activities of daily living, except with grooming, which he needed assistance, and the resident also needed assistance with self-administration of medications. In an interview with the administrator on at 11:55am, he stated that the facility did not produce an incident report to document what happened to resident #16 on . He stated that he was aware that resident #16's progress notes did not have enough detail to determine who were the staff members who responded to the resident, to describe the resident's specific condition or the specific times when personnel arrived to the facility and declared the resident to be . He stated that he believed that resident #16 , from a but he was not certain because the facility did not obtain the report and the facility staff members did not document this in the progress notes. In an interview with Staff D on at 12:20pm, she stated that she was a resident caregiver, she	A 077		

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A 077	Continued From page 5 worked in the facility on and she responded to resident #16's room when resident #9 notified her that the resident was on the floor. She stated that she didn't know the exact time when this took place at and she was not asked by administration to document her observations to describe what happened to resident #16 on . In an interview with Staff C on at 8:40am, she stated that she was a resident caregiver, she worked in the facility on and she responded to resident #16's room after resident #9 notified her that the resident was on the floor. She stated that she was working on the 11pm-7am shift which started the night before on . She stated that she found Resident #16 unresponsive on the floor inside his bedroom at approximately 2:00am and she had staff D call 911 while she performed , on the resident. She stated that her and staff D were the only staff members in the facility at that time and they were responsible for the care of the residents in the facility. She stated that she verbally notified her supervisor and the administrator of what happened to Resident #16 later that morning, she was not asked by administration to document her observations to describe in detail what happened to resident #16 on . In an interview with the Administrator on at 12:05pm, he stated that he did not require any of the 2 direct care staff members (Staff C and D) who were present to document their observations relating to the care Resident #16 received before passing away in the facility on . He stated that the facility did not have any documentation reflecting an internal investigation of the incident of regarding Resident #16. He was also	A 077		

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A 077	Continued From page 6 unable to provide documentation indicating interviews conducted with staff present, to include the time notified of the emergency regarding Resident #16, time staff responded, the exact time was initiated, and whether staff followed appropriate procedures when responding to an emergency. The information gather from Staff C and D during interviews conducted by the surveyor was not supported by written documentation within the facility. Class	A 077		