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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 AMENDED REPORT An unannounced Complaint survey (#2023011784, #2023017259, #2023013646, #2023017105, #2024000399, #2024001037, #2024002881, #2024003440 & #2024003489) and a Generator Monitoring survey were conducted on through at Cresthaven. The facility had deficiencies related to complaints #2023017259, #2024000399, #2024002881 & #2024003489 identified at the time of the visit. A Class I deficiency was identified at A 0092.	A 000		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all	A 030		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 1 residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . ., Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . ., neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with	A 030		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 2 convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.	A 030		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 3 (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 4 case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state	A 030		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 5 that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review and	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 6 interviews, the facility failed to have a written Grievance Policy and Procedure that was implemented and effective for 4 out of 4 sampled residents (Residents #3, #4, #11 and #13). The findings included: 1. On at 12:16 PM, Resident #3's representative stated during a telephonic interview that the resident's refund was not received within 45 days of discharge, and that the Administrator was notified about the concern in his office on or about . She stated that the resident moved out of the facility on , after giving a 30 day notice on . Review of the facility's accounting and refund documentation for this resident shows the resident's "vacated" date was and that the resident's refund was prepared on . The Payment Detail sheet shows the refund check was disbursed on or about . 2. On at 9:27 AM, Resident #10's representative stated during a telephonic interview that the resident's apartment was treated for bed bugs by the Maintenance Director after showing the bugs to him directly on or about . The resident was taken home by the representative while the room was treated and a chair was discarded. The representative stated a grievance was attempted to be filed by asking a front desk representative on or about for a "report to be filed" and the representative stated there was "no form to file". It was also reported that the bugs were not successfuly treated, and that they were observed in the resident's room after the treatment was completed. On , the Pest Control Bed Bugs Log was reviewed, and did not show this resident's room	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 7 as a treated area. At approximately 2:00 PM on this date, the Maintenance Director stated during interview by phone with the Administrator present that this room was never treated for bed bugs and that he was not aware of any report of bugs for this room. 3. On at 4:55 PM, Resident #11's representative stated during a telephonic interview that various facility staff, including the Director of Nursing (DON) and Administrator, have been notified on multiple occasions of concerns with unsanitary food service, hygiene supplies missing in the resident's room, missing personal items, staff speaking a language different than the language residents' can understand and pest control. He stated the last meeting with the Administrator was on or about ("two Fridays ago"). He stated that the concerns are repetitive and that soap is now provided by him in the resident's room as there was no other resolution by the facility for that concern. 4. On at 11:04 AM, Resident #13 stated during a telephonic interview that his was not delivered to his apartment on or about , and that staff were not able to locate it. He stated that the was provided to him eventually, but that it was another resident's supply. The resident said he had notified the Administrator of this grievance, but it had occurred again afterwards. On Resident #9 was observed at the facility encountering a similar issue. The resident went to the front desk at approximately 3:00 PM to ask for her delivered medication, and stated that she had been informed that it was delivered on (6 days earlier). The front desk	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 8 representative stated to the resident, "All medication goes to the 2nd floor nurses' station" and did not offer the resident any assistance in finding the medication. Resident #9 and this writer went to the nurses' station and after many checks with other staff, medication carts, the supply in the nurses' station, the medication was located. When describing the incident to the DON on . . . . . at 3:30 PM, she stated that "no medications go to the nurses' station for self medicating residents or PACE residents" and immediately counseled the front desk representative. It is unknown what further actions will be taken to ensure that the front desk is not sending medication somewhere else in facility other than to residents who self-medicate, causing a delay in the receipt of delivered medication. Review of the facility's Grievance Policy and Procedure notes the following steps to be taken for grievances: 2. The resident or responsible party should discuss the concern/complaint/recommendation with the Executive Director (ED) or designee. The ED will involve the appropriate Department to resolve the concern/complaint/recommendation. 3. If unable to resolve grievance with step 2, the grievance should be submitted in writing to the ED. The ED should respond to the resident or responsible party within seven (7) days of receipt of the complaint. Review of the Grievance log that tracks incoming grievances and responses was reviewed, and had no grievances had been documented from Residents #3, #4, #11 and #13 in 2023 or 2024.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 030	Continued From page 9 There were no grievances logged from any residents or representatives from through . . . . . It could not be determined if the grievances noted above were communicated to the Department Heads for resolution as the policy and procedure requires. It is unknown if the facility took any actions to resolve the concerns that were communicated to the facility, and if the actions were effective in resolving the issues. Additionally, the requirement that a resident or representative must submit a grievance in writing for a timeline to be instituted for resolution of a grievance, without any assistance or encouragement by staff to facilitate the written grievance, is not an effective policy that ensures residents are able to easily communicate concerns to be addressed. Class III	A 030		
A 092	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices.	A 092		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 092	Continued From page 10 (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that food service provided by the facility was completed in a safe and sanitary manner to all current residents. The resident census was a total of 231 residents throughout the survey from . . . . . to). The findings included: On , a Department of Health representative completed a routine inspection of the facility's food service areas. The Inspection Report notes that the inspection was "unsatisfactory" due to "infestation concerns and excessive violations". The report documented, "All evidence of cockroaches and fruitflies must be cleaned from establishment as well as correction of all violations".	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 092	Continued From page 11 On , a Department of Health representative completed a reinspection of the facility's food service areas. The Inspection Report notes that the inspection was "unsatisfactory" due to "infestation concerns and excessive violations". The report documented, "All evidence of cockroaches and weevils must be cleaned from establishment as well as correction of all violations". A Formal Notice To Correct Violation dated . . . . . completed by the Department Of Health indicated, "Live and cockroaches observed throughout the establishment (service line, ware washing area, dry storage, food preparation line). This violation must be corrected in 3 days". On . . . . . , a Department Of Health representative completed a reinspection of the facility's food service areas. The Inspection Report notes that the inspection was "unsatisfactory" due to "infestation concerns and excessive violations". The report documented, "All evidence of cockroaches and weevils must be cleaned from establishment as well as correction of all violations". It also references, "a notice to correct has been issued for the facility". On , a certified letter from the Department of Health noted the following, "On . . . . , the Routine inspection received nine (9) violations one of which was for the presence of a cockroach infestation. This was determined by the observation of over 20 live cockroaches and several ones throughout the establishment. A follow-up reinspection was set for . . , and over 15 live roaches were observed throughout the establishment. The next reinspection, today , the	A 092		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 092	Continued From page 12 reports and current conditions was discussed with the Business Office Manager (BOM) and the kitchen manager along with my supervisor Environmental Manager. The (BOM) was not aware of the previous inspections, however the kitchen manager stated the kitchen has been cleaned and the pests' issue was fixed. The pest issue is still ongoing by evidence of over live and . . . . cockroaches throughout the establishment. For the above reasons you are out of compliance with section 381.0072 Florida Statutes and the requirements of 64E-11 F.A.C. Enclosed in this letter is a Formal Notice to Correct Violation set to correct within 3 business days of receipt of this letter to come into compliance. The inspection reports from , 6, and 7, 2024 have also been included". On . . . . . , a Department of Health representative completed a reinspection of the facility's food service areas. The Inspection Report notes that the inspection was "unsatisfactory" due to "infestation concerns and excessive violations". The report documented, "All evidence of cockroaches must be cleaned from establishment as well as correction of all violations". It also referenced, "a notice to correct has been issued for the facility". On , a " delivered" Emergency Suspension of Food Sanitation Certificate and Order to Cease Operating All Food Service at Facility was issued to the facility to notify them that the Food Sanitation Certificate was temporarily suspended. The letter documented the following: "...the Department inspected your facility on the following dates: . . , . . . , . . , ... , , , and , , and	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 092	Continued From page 13 11, 2024, and found evidence of a substantial cockroach infestation including numerous live and . . . . roaches. Despite issued warnings, the problem has persisted for the four calendar days. Further, there were numerous live and . . . cockroaches in the fryer and the dishwasher...the Department finds that there is an immediate serious danger to the public health, safety and welfare of your residents which requires immediate temporary suspension of your Sanitation Certificate and immediate cessation of the operation of your kitchen for any food services. You must cease operating the kitchen and provide your residents with meals through alternative means. The Department's action is warranted under the circumstances as it is the only way at present to ensure that the cockroaches do not contaminate the food products being supplied to your residents". During interview with the Administrator and the Food Service Director (kitchen manager) on . . . . . at 12:00 PM, it was revealed that the facility was not utilizing the kitchen and a scheduled cleaning and pest control treatment by two different companies was to take place the evening of . . . . . . At 5:15 PM on . . . . . , the Administrator confirmed during an interview that the monitoring of safe food handling would be completed by himself (under his supervision instead of under the supervision of the FSD). An interview was conducted with the Administrator on at approximately 5:15 PM regarding the facility's plan to provide meals to the 231 residents 3 times a day. The Administrator stated they were using their emergency plan food supply. The emergency plan food supply consisted of . . . food meal items from the refrigerated truck on grounds	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 092	Continued From page 14 based on a limited availability menu. The items were dry cereal, sandwiches, ravioli (canned) heated in a microwave by staff in the dining area. The refrigerated truck with the food items was on the facility grounds on (located in the front parking lot near kitchen door). The surveyor informed the Administrator that this is not a hurricane (natural disaster) but more of a lack of compliance with respect to 381.0072 Florida Statutes and the requirements of 64E-11 F.A.C. per DOH. And that the residents should not suffer with the lack of nutritional/healthy/hot meals due to lack of compliance by the FSD and Dietary staff. He stated, he agreed and that he would have the meals catered during the periods in which the kitchen was closed. On the day of AHCA's (Agency for Healthcare Administration) survey on at approximately 9 AM, during a tour of the kitchen area and the dining area, evidence of surface cleaning only, evidence of the same problems noted by DOH were observed by the surveyors. The dining area was observed with multiple chairs, tables, and walls with a large accumulation of unknown matter of debris. The Dry Storage food area (located in the of the kitchen) was observed with insect dropping on canned food, and the walls had a large accumulation of unknown matter of debris. It was further observed that the food storage shelving area had not been cleaned and wiped down, as ordered by DOH. The Food Service Director (FSD) stated at 9:30 AM on , that he cleaned the kitchen. However, the Administrator on at 9:38 AM informed the FSD that the area was still not clean and agreed the facility was still not in compliance. At this time, the Administrator agreed that they were not ready for DOH reinspection as originally , for	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 092	Continued From page 15 . . . . . . During an interview and observations with the Administrator on at 9:45 AM, ordered an immediate meeting with FSD and all Dietary Staff (in the dining area of the facility). The Administrator informed the staff that the kitchen and dining area was unacceptable, he immediately ordered all the items in the kitchen and dining removed and taken out for extensive deep cleaning. During an interview with the Administrator on at 11:40 AM, he was asked if the facility had a policy and procedure to manage and monitor the sanitation of the kitchen and dining area. The Administrator stated the FSD didn't have any documentation but going forward they would create protocols for the FSD and dietary staff to follow to prevent this reoccurrence. During an interview at 1:15 PM on , the Chief Operating Officer(COO) had arrived on the grounds and would be touring the kitchen and dining area. The COO stated at approximately 1:47 PM on , that the kitchen and dining areas were unacceptable and that he would need to hire an outside cleaning crew to deep clean and paint the entire kitchen area and dining area. He stated he was already working on the details and that they should start tomorrow or late tonight. During random confidential interviews with residents on and , residents were seen cheering and excited during the breakfast, lunch, and dinner meal teams regarding the catered meals. Residents constantly voiced that they were tired of the "	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 092	Continued From page 16 and nasty" food. They stated they were glad to finally have hot full meals. Review of "www.WebMD.com" website on revealed the following dangers of cockroaches, "they can carry substances such as feces on their body. They can release these substances into the air, causing reactions or . The debris from roaches, body parts, or poop also can trigger or . Roaches can also contaminate your food, utensils, and even the surfaces where you prepare your food. This may cause health hazards such as food , and ". During a review of the FSD and Dietary Staff personnel files on , it was revealed that no additional in-service had been completed regarding the sanitation protocols to prevent reoccurrence of the pest infestation and sanitation issues identified by DOH from to current date. During an interview with the Business Office Manager on at 10:30 AM, she confirmed no documentation existed in the file. She stated she would check with the FSD because she believes the Dietician had conducted training a couples weeks ago. The FSD arrived around 10:45AM and provided a blank certificate of attendance for Nutrition and food service in assisted living facilities, food & nutrition director training, food safety/food handling, FAC Chapter 64 E-11, Food Code (1 contact hour) dated , with the Dietician's name and credentials. The FSD was requested to provide training certificates for all the dietary staff for this training. At this time, he stated he had not completed the certificates and	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 092	Continued From page 17 that the Dietician provided him with this blank copy and told him to fill out for each of his staff members that had attended the training on . The FSD provided a sign-in sheet for the training which listed 19 Dietary staff members and the FSD (total of 20 Dietary staff members) . The Administrator was informed on at 1:15 PM that the residents were extremely unhappy with the prior meals served due to the kitchen closure. The Administrator stated that this situation with the kitchen closure made him realize that major changes need to occur with the dietary management and staffing services. He agreed that things should not have gotten to this level of unsanitary findings regarding food service as identified by DOH and AHCA inspection. During an exit interview with the Administrator, DON, and COO on at 1:30PM, all of the concerns identified by DOH and the surveyor were discussed. The Administrator, DON and COO agreed that the kitchen was not ready for reinspection by DOH and confirmed it would take a couple of additional days as they wanted to hire outside cleaning crew for cleaning and painting replacement of equipment. They also confirmed that the kitchen closure by DOH could have been prevented had the FSD and staff followed the appropriate sanitation procedures and the violations order requirements. Class I	A 092		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall	A 161		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 161	Continued From page 18 maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed	A 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 161	Continued From page 19 staffing agency or staff employed by an entity ␣ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, the facility failed to maintain personnel records with a job description, for 5 out of 6 sampled Staff.(Staff F J, K, L, and I) The Findings include: Record review conducted of personnel file for Staff C with a hire date of revealed a job description of Food Service Director. During an interview with the Business Office Manager on at 9:35 AM, she stated Staff C is the Food Service Director for the facility and responsible for training all of the kitchen staff. At this time,the job description was reviewed, it showed that the the Food Service Director must possess a high school diploma or G.E.D. and must be experienced in employee supervision. However, further review of Staff C file failed to indicate a diploma/G.E.D or documentation of experience in employee supervision. Further interview with the Business Office Manager and the Administrative/HR Assistant, a request was made for proof of aformentioned documentation for Staff C. At this time, she stated she would go check with Staff C. Upon her return at 10 AM, she was unable to produce the documentation. She	A 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 161	Continued From page 20 stated he didn't have a diploma or G.E.D, she stated he had been working her in the facility in this position for over 20 years. Record review conducted of personnel file for Staff F with a hire date of revealed a job description of Dining Room Server. During an interview with the Business Office Manager on at 9:56AM, she stated Staff F is the Assistant Kitchen Manager. At this time, the job description in the file was reviewed with the Business Office Manager, she confirmed it didn't match her current job title and duties as Assistant Kitchen Manager. She further stated, the facility had not updated her job description and that she had been in this position for a couple of years. Record review conducted on revealed Staff J had a hire date of as a Food Preparation Worker as documented on the facility's staff listing roster. In an interview with Administrative/HR Assistant on at 10:34AM, she stated she had requested a job descriptions from the Administrator but it was never provided. Further review of the personnel file revealed Staff J had no job description on file. Record review conducted on revealed Staff K had a hire date of as a Kitchen Prep Worker as documented on the facility's staff listing roster. Further review of the personnel file revealed Staff K had no job description on file. Record review conducted on revealed Staff L had a hire date of as a Dietary Manager the as documented on the facility's staff listing roster. Further review of the personnel file revealed Staff L had no job description on file.	A 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 161	Continued From page 21 Record review conducted on revealed Staff I had a hire date of as a Kitchen Prep Worker as documented on the facility's staff listing roster . Further review of the personnel file revealed Staff I had no job description on file. During an interview conducted with the Administrator on at 1:34 PM, he acknowledged the findings. No documentation was provided during the Survey. Class III	A 161		
A 170	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a refund that was due to a resident upon discharge was disbursed within 45 days as required for 1 out of 3 sampled residents (Resident #3). The findings included: On , the accounting of Resident #3's payments and refund upon discharge was reviewed. The Payment Detail showed the	A 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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 170	Continued From page 22 resident "vacated" the apartement on . . . . and a refund was disbursed on or about . . for $911.60. During interview with the resident's representative on . . . . . at 12:16 PM, she stated that the move out date was , and that the notice to vacate was provided to the facility 30 days prior to that date as required for a refund to be provided for a prorated amount the remaining days of , . The representative provided a copy of the facility's Room Release Form dated that showed the resident's belongings were moved out of the room. The refund was required to be provided within 45 days of the move out date of . . . . . . Upon further inquiry with the Business Office Manager at the facility, on at 7:58 AM an email confirmed that the refund disbursed to the resident's representative was late "because a new system change resulted in a delay in processing refunds". Class III	A 170		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective [illegible], or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before [illegible], initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective [illegible], initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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
CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain an updated employment status roster in the Background Screening Clearinghouse system within 5 business days after a person receives his or her initial status for 29 out of 111 sampled staff (Staff B, L-N2).. Findings included: Review of the facility's Background Screening Clearinghouse Roster (BGS) showed: 1) Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff B, who was hired on as Director of Nursing did not maintain the employment or affiliation status on the BGS roster. 2) Review of the facility's staff listing roster revealed Staff L was hired as a (Home Health	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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
CZ814	Continued From page 2 Aid) HHA on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff L, was not listed, no employment or affiliation status on the BGS roster. 3) Review of the facility's staff listing roster revealed Staff M was hired as Kitchen Prep Staff on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff M, was not listed, no employment or affiliation status on the BGS roster. 4) Review of the facility's staff listing roster revealed Staff N was hired as Kitchen Prep Staff on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff N, was not listed, no employment or affiliation status on the BGS roster. 5) Review of the facility's staff listing roster revealed Staff O was hired as an Administrative Assistant on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff O, was not listed, no employment or affiliation status on the BGS roster. 6) Review of the facility's staff listing roster revealed Staff P was hired as a Maintenance Staff on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff P, was not listed, no employment or affiliation status on the BGS roster. 7) Review of the facility's staff listing roster revealed Staff Q was hired as a Front Desk Staff	CZ814		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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
CZ814	Continued From page 3 on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff Q, was not listed, no employment or affiliation status on the BGS roster. 8) Review of the facility's staff listing roster revealed Staff R was hired as a Transportation Staff on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff R, was not listed, no employment or affiliation status on the BGS roster. 9) Review of the facility's staff listing roster revealed Staff S was hired as a Housekeeper on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff S, was not listed, no employment or affiliation status on the BGS roster. 10) Review of the facility's staff listing roster revealed Staff T was hired as a Housekeeper on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff T, was not listed, no employment or affiliation status on the BGS roster. 11) Review of the facility's staff listing roster revealed Staff U was hired as a Housekeeper on [redacted]. Record review of the facility's Background Screening Clearinghouse Roster conducted on [redacted] revealed Staff U, was not listed, no employment or affiliation status on the BGS roster. 12) Review of the facility's staff listing roster revealed Staff V was hired as a Housekeeper on	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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
CZ814	Continued From page 4 . . . . Record review of the facility's Background Screening Clearinghouse Roster conducted on . . . . . revealed Staff V, was not listed, no employment or affiliation status on the BGS roster. 13) Review of the facility's staff listing roster revealed Staff W was hired as a Housekeeper on . . . . . Record review of the facility's Background Screening Clearinghouse Roster conducted on . . . . . revealed Staff W, was not listed, no employment or affiliation status on the BGS roster. 14) Review of the facility's staff listing roster revealed Staff X date of hire was as Housekeeper but was terminated . . . . . per the Business Office Manager. However, review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff X was not listed, no employment or affiliation status on the BGS roster. 15) Review of the facility's staff listing roster revealed Staff Y was hired as a Housekeeper on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff Y, was not listed, no employment or affiliation status on the BGS roster. 16) Review of the facility's staff listing roster revealed Staff Z was hired as a Housekeeper on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff Z, was not listed, no employment or affiliation status on the BGS roster. 17) Review of the facility's staff listing roster	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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
CZ814	Continued From page 5 revealed Staff A2 was hired as a Admissions Director on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff A2, was not listed, no employment or affiliation status on the BGS roster. 18) Review of the facility's staff listing roster revealed Staff B2 was hired as a Admissions Director on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff B2, was not listed, no employment or affiliation status on the BGS roster. 19) Review of the facility's staff listing roster revealed Staff C2 date of hire was as the Admission Director but was terminated as of ..... by the Business Office Manager . However, review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff X was not listed, no employment or affiliation status on the BGS roster. 20) Review of the facility's staff listing roster revealed Staff D2 was hired as a Certified Nursing Assistant (CNA) on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff D2, was not listed, no employment or affiliation status on the BGS roster. 21) Review of the facility's staff listing roster revealed Staff F2 was hired as a (CNA) on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff F2, was not listed, no employment or affiliation status on the BGS roster.	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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
CZ814	Continued From page 6 22) Review of the facility's staff listing roster revealed Staff G2 was hired as a Licensed Practical Nurse (LPN) on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff G2, was not listed, no employment or affiliation status on the BGS roster. 23) Review of the facility's staff listing roster revealed Staff H2 was hired as a (LPN) on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff H2, was not listed, no employment or affiliation status on the BGS roster. 24) Review of the facility's staff listing roster revealed Staff I2 was hired as a (Home Health Aid) HHA on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff I2, was not listed, no employment or affiliation status on the BGS roster. 25) Review of the facility's staff listing roster revealed Staff J2 was hired as a CNA on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff J2, was not listed, no employment or affiliation status on the BGS roster. 26) Review of the facility's staff listing roster revealed Staff K2 was hired as an HHA on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff K2, was not listed, no employment or affiliation status on the BGS roster.	CZ814		

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
	AL11910367	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

(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
CZ814	Continued From page 7 27) Review of the facility's staff listing roster revealed Staff L2 was hired as a CNA on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff L2, was not listed, no employment or affiliation status on the BGS roster. 28) Review of the facility's staff listing roster revealed Staff M2 was hired as a CNA on /20023. Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff M2, was not listed, no employment or affiliation status on the BGS roster. 29) Review of the facility's staff listing roster revealed Staff N2 was hired as a CNA on . Record review of the facility's Background Screening Clearinghouse Roster conducted on revealed Staff N2, was not listed, no employment or affiliation status on the BGS roster. On at 1:34 PM, during an interview with the Administrator he was informed of the Level II Background Screening requirement, he acknowledged the findings and stated he will have it done. Unclassified	CZ814		