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 _____	04/28/2025

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

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A 000	Initial Comments An unannounced Limited Nursing Services (LNS) Monitoring survey was conducted on at Cresthaven. The facility had deficiencies at the time of the visit.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

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A 010	Continued From page 1 who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010		

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a Resident Health Assessment 1823(AHCA form 1823) form was accurately completed and reflective of the resident's current health status and care needs, for 1 of 1 sampled resident (Resident #1) admitted to the facility requiring lower extremity care treatments. The findings include: Review of Resident #1's medical record indicated the resident has medical diagnosis' including , below left and multiple open on the lower right extremity and . The resident is non-ambulatory and uses a wheelchair for mobility. Further review of Resident #1's medical record revealed progress notes that the resident was admitted to the facility on with to his right ankle and great and was wearing a large orthopedic protective . Review of Resident #1's current Resident Health Assessment,1823, dated indicated no documentation of the resident's required care since admission to the facility. In an interview with the Director of Nursing on at approximately 1:30 PM she stated that Resident #1 was admitted with lower extremity which required care treatment. She stated that the facility nurses were not performing care, but the Home Health Agency nurse was caring for the . She reviewed the current 1823 Health Assessment 1823 form and agreed that it did not	A 010		

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A 010	Continued From page 5 reflect the current nursing treatments for the resident. Class III	A 010		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 6 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care and services appropriate to meet the needs of the residents. As evidenced by the failure to provide ongoing nursing assessment/ monitoring for 2 of 2 sampled residents with , Resident #1 with a / with and Resident #2 with a history of . The findings include: 1. On at approximately 2 PM Resident #1 was observed sitting in a wheelchair. His left was surrounded by a metal immobilizer	A 025		

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A 025	Continued From page 7 device and the top of his left / were exposed. Review of Resident #1's medical record indicated the resident was admitted to the facility on with medical diagnosis including , below left and multiple open on the lower right extremity and . Review of Resident #1's current Resident Health Assessment,1823, dated indicated the resident was independent for all Activities of Daily Living (ADL). Under the Nursing/ Treatment Requirement section of the form indicated "evaluate and treat". There was no documentation of the residents' required care. Review of Resident #1's medical record revealed progress notes on admission to the facility on , resident has to his right ankle and great . The is noted to be dark, calloused, flaky with poor circulation. Resident #1 was wearing a large orthopedic protective on the right . Further review of Resident #1's progress notes dated indicated a written fax order for care by home health agency. Review of Resident #1's progress notes indicated no nursing assessment/ monitoring of resident's left . Further review of the progress notes from do not indicate if the home health agency nurse is providing care. Review of Resident #1's progress notes indicated on the resident goes out to a medical for evaluation of his and is	A 025		

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A 025	Continued From page 8 admitted to the hospital. Review of a progress note dated indicated Resident #1 returns to the facility with a " ˬ immobilizer" in place. Further review of Resident #1's progress notes indicate no documentation of any nursing assessment/ monitoring of the resident's on readmission. Review of the facility progress notes for Resident #1 after indicate no documentation of any nursing monitoring of the resident's , condition or status. Review of the facility progress note dated indicted Resident #1 is seen by the physician , and care orders are written for Silver 1 % cream to be applied daily to the right for 30 days. The note indicates the order is faxed to the pharmacy and home health agency. Further review of the facility progress notes indicates no documentation of nursing monitoring of Resident #1's right ˬ and if treatment is performed by the home health agency. Review of the facility progress note dated indicted Resident #1 is seen by the physician , and orders are written, as well as an ˏ is ordered of the right ankle. The note indicates the ˏ provider is notified of the order. Further review of the progress notes indicates no documentation by the facility nursing staff of the resident's status with new medication order and results of the ordered ˏ. Review of the Home Health Agency nursing visit notes dated indicates Resident #1 is	A 025		

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A 025	Continued From page 9 being treated for an open draining on the right . care orders include to "apply cream (caution with) to and cover with Adaptic . Wrap pin sites with gauze, followed by Kling . wrap around ex-fixer 3 x weekly". In an interview with the Director of Nursing (DON) on at approximately 1:30 PM she stated that Resident #1 was admitted to the facility with open on his left lower extremity. She stated that the resident was and had poor circulation in his right . She stated that the resident had had a prior left conditions. The DON stated that the facility nursing staff were not performing care for Resident #1. She stated that a Home Health Agency Nurse visited the resident 3 x week to perform care. When the DON was questioned if she was involved in care, she stated that she was not. She stated that the facility 3rd party policy requires the 3rd party provider staff to complete a "communication sheet" after any treatments are performed on a resident and then also communicate with her about the status of the resident. The DON stated that she had not observed Resident #1's and did not have any details on the status. She stated that the Home Health Agency Nurse is visiting Resident #1 to perform care, but she could not provide any documentation of the visits as per the facility policy. The DON stated that there were Licensed Practical Nurses employed by the facility. 2. On at approximately 12 PM Resident #2 was observed lying in his bed. In a brief interview with the resident, he stated that he is paraplegic and has a history of	A 025		

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A 025	Continued From page 10 , due to his immobility. Resident #2 stated he currently had an "open "spot on his left , . The DON was present when Resident #2 rolled over slightly to show an open on his left , . No was observed covering the area. The resident stated that the Home Health Agency Nurse has concerns with the new and was treating the 2 x week. Review of Resident #2's medical record indicated the resident was admitted to the facility on . Review of the Resident Health Assessment form 1823 dated indicated the resident had medical history of , Prostatic Hyperplasia ( ), s/p gun shot , , and , . The form indicated the resident is non ambulatory, wheelchair bound and has a history of , . Review of Resident #2's progress note dated on admission reveals the resident has an open quarter size on his , area. The resident is documented as informing DON that it opens a lot but heals. Home health agency evaluation orders are obtained. Review of the facility progress notes for Resident #2 reveal no nursing documentation from admission regarding observation /monitoring and care performed. Review of Resident #2's progress note dated indicated the resident was found on the floor in his room. The resident claims he slid off the bed landing on the floor and had no injuries. The nurse on duty documents an observation of an open on Resident #2's left . A care order evaluation was obtained, per the nurse's note.	A 025		

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A 025	Continued From page 11 Review of the facility progress notes for Resident #2 reveal no nursing documentation regarding observation /monitoring and care performed. Review of the Home Health Agency nursing visit notes dated indicated a , , left lateral , 2.5 cm open and reddened with small amount . reopened with undermining present. Surrounding skin is fragile. care performed with foam applied which resident does not tolerate well per note. In an interview with the Director of Nursing (DON) on at approximately 1:30 PM she stated that Resident #2 was admitted to the facility with an open on his . She stated that the resident is paraplegic and has a history of , due to immobility. The DON stated that the facility nursing staff were not performing care for Resident #2. She stated that a Home Health Agency Nurse visited the resident to perform care. When the DON was questioned if she was involved in care, she stated that she was not. She stated that the facility 3rd party policy requires the 3rd party provider staff to complete a "communication sheet" after any treatments are performed on a resident and also communicate with her about the status of the resident. The DON stated that she had not observed Resident #2's and did not have any details on the status. She stated that the Home Health Agency Nurse is visiting Resident #2 to perform care, but she could not provide any documentation of the visits as per the facility policy. The DON stated that there were licensed practical nurses employed by	A 025		

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A 025	Continued From page 12 the facility. Class III	A 025		
AN277 SS=D	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in Rule 59A-36.006, F.A.C. (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community.	AN277		

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AN277	Continued From page 13 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain the required regulatory documentation for the Limited Nursing Services (LNS) licensure. As evidence by the failure to employ or contract with a professional nurse to coordinate 3rd party services needed by the residents under the LNS license. The findings include: Review of Florida Health Finder.Gov website on indicated that the facility has a Standard and Limited Nursing Services Assisted Living Facility license # 4769, effective from - . In an interview with the Administrator on at approximately 10:30 AM, he acknowledged that the facility has a standard and limited nursing services license. A request was made to review the required personnel file for the facility's designated LNS nurse responsible for the coordination of resident care. The Administrator stated that there was no contract for a designated LNS Registered Nurse (RN) since . In an interview with the Director of Nursing at that same time she stated that there were only Licensed Practical Nurses (LPN) employed at the facility and there were no registered nurses. She acknowledged that the previous LNS nurse had resigned and there was no replacement. Class III	AN277		