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 _____	06/11/2025

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

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A 000	Initial Comments An unannounced Licensure Complaint survey, complaint #2025008161, was commenced on and concluded on at Crest Manor. Deficiencies were identified at the time of survey. Class I deficiencies were found at A 0025, A 0030, A 0077, A 0152 and A 0182. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. As a result of this Licensure Complaint survey conducted at the facility, imminent danger concerns were identified resulting in Class I deficiencies related to Resident Care , Staffing Standards, Physical Plant and Emergency Management.	A 000		
A 025	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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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 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	A 025		

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A 025	Continued From page 2 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide supervision as appropriate for each Resident during an emergency in which the facility was experiencing signficiant problems with their air conditioning system (central air unit and individual wall units), the system was not functioning appropriately to maintain the facility's internal temperatures at or below 81 degrees Fahrenheit(F), for a census of 42 residents (Residents #). The facility also was without the direction and supervision of an Administrator or Designee during this emergency. The findings included: On and the facility census was identified and confirmed by the Administrator (the Provider) as 42 residents. Review of the residents' Health Assessments revealed all required assistance and/or supervision of activities of daily living (toileting, , grooming, , transfer and ambulation). In addition, many of the residents required assistance with medications. Further review revealed 1 out of 42 (Resident #5) residents was enrolled in Hospice Services. The facility's floor plan revealed the following information: 1st floor- 6 rooms, 10 residents resided on this floor 2nd floor-12 rooms, 15 residents resided on this floor 3rd floor- 6 rooms, 9 residents resided on this floor	A 025		

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A 025	Continued From page 3 4th floor- 6 rooms, 8 residents resided on this floor A record review of the facility's grievance notebook/binder revealed the Provider's climate control problems began on or about , with the main air conditioning system and individual cooling units throughout the facility failed to operate/function appropriately resulting in temperatures above 81 degrees. Although, the facility was aware of this problem around , the facility failed to establish and implement procedures to ensure that all residents were monitored for heat exhaustion and the temperatures were monitored in the building to determine if any emergency relocation procedures were needed prior to emergency evacuation due to the dangerous temperatures within the building. On at 8:50 PM Palm Beach County Sheriff's Office (PBSO) responded to an altercation between residents (Resident #1 & # 2) at the facility. PBSO, upon arriving on scene, discovered the building was hot. Due to the extreme temperatures of the building, PBSO contacted the local fire department for further evaluation of the temperatures within the building. The Fire Marshal and Palm Beach County Fire Rescue (PBCFR) arrived to the scene to further investigate the temperature concerns. PBSO were also summoned by other residents at the time of their visit regarding the extreme heat temperatures. Upon arrival of the local Fire Rescue on around 9 PM, their investigation found that multiple rooms (14 rooms) were identified as having temperature readings above 81 degrees Fahrenheit (F). The Administrator was ordered to	A 025		

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A 025	Continued From page 4 evacuate the residents in those rooms above 81degress to other areas/rooms in the facility with appropriate temperature (below 81 F). The local fire department, due to the extreme temperature within the building, remained on-site. PBCFR issued a Cease and Desist order for these rooms. On at 12:15 AM (effective date and time), Palm Beach County Fire Rescue issued a "Cease and Desist by Order of the Fire Marshal". A review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. The following rooms are to be vacated: 101, 100, 104, 201, 203, 204, 205, 208, 209, 210, 212, 408, 410, 407, 412. The Administrator, after Palm Beach County Fire Rescue intervened, was able to get the temperature below 81 F for the following , , , 410, 412, 407. However, the Administrator was unable to bring the additional rooms as listed in the cease order to temperatures below 81 F. Therefore, the Cease and Desist order remained in place. On at 12:45 PM, upon entering the first floor of the facility (main entrance area) temperatures were noted to be hot . The temperature readings were recorded as 83 degrees Farenheit. It was observed that the exhaust vents located in the first floor common area were not yielding air; hot air was coming out of all vents (4 total). An additional tour of the building at 1:05 PM revealed all floors (2nd-4th floor) were extremely warm including the stairwells for each floor. Based on additional observations on at 1:15 PM, the	A 025		

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A 025	Continued From page 5 stairwells were used regularly by residents to go between floors due to the building only having 1 elevator. The elevator was also noted to be extremely hot. Further observations revealed that the facility's Administrator had not followed the order as issued on at 12:15 AM and allowed residents to use rooms (204, 205, 208, 210 and 212) that were ordered to be evacuated by the Fire Rescue. The order was issued due to the facility temperatures in various residents' rooms reaching dangerous level above 81 degrees. This placed the residents in danger due to extreme heat exposure. During an interview with the Administrator on at 1:25PM, he was questioned regarding the occupancy of the rooms (204, 205, 208, 210 and 212) that were ordered to be evacuated by the cease order on . . . . . at 12:15 AM. He stated that he thought he could use the rooms since he had fixed the individual wall units in the rooms. He was also asked if he had obtained permission from PBCFR to reoccupy those rooms, he stated "No". At this time, he stated that he would immediately move the residents to other rooms. The Administrator was asked how he planned to ensure that the rooms were not reoccupied. The Administrator and the Office Manager stated they would lock the doors and place a signage on the door that stated, "Do Not Use". Additionally, the Administrator was asked what procedures had been implemented for staff to follow to monitor the residents' safety, provide hydration and increase hydration. The Administrator stated he didn't have a plan. He also stated, he had not appointed a designated person in charge, even after the emergency notification regarding the air conditioning system by PBSO, PBCFR and the	A 025		

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A 025	Continued From page 6 Senior Planner on . At this time, the Administrator was reminded that he needed to monitor the residents' safety and well-being, the temperatures throughout the facility and supervise the residents to ensure they are not allowed in areas deemed unsafe by the PBCFR. The Administrator was also informed that these concerns were previously brought to his attention during his review of the facility's CEMP on during the initial assessment by emergency crews. Additional observations of the building on revealed as the afternoon and evening hours approached (3 PM -5 PM), the temperatures throughout the building increased tremendously. At 5:00 PM on , the temperatures were above 81 degrees and the Fire Department ordered the Provider (the Administrator) to close the fourth floor due to unsafe temperatures and relocate the residents to other floors within the facility. Throughout this period multiple residents in the building were seen seeking areas to cool off. Some of the residents were seen with their upper body clothing wet due to them sweating profusely from the extreme heat within the building. Many of the residents were sitting outside and some even attempted to come into the Administrator's office, that had a separate a/c system from the entire building (mini split air conditioning system).This system only cooled the Administrator's office. On at approximately 6:45 PM the PBCFR issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped	A 025		

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A 025	Continued From page 7 when any of the following exist: (c) an imminent danger to life and safety has been created. Entire Facility/Occupancy. Even after the final Cease and Desist Order was issued, the temperatures within the building still remained unstable, resulting in the building still remaining extremely hot and multiple areas in the building and residents' rooms had temperature readings above 81F. The facility had approximately 4 Direct Care staff on duty at the time of the incident on for a census of 42 residents. During the hours of 12:45 PM to 7 PM, staff had not provided any additional hydration to the residents or set-up hydration stations. After surveyor intervention, the staff was seen retrieving pitchers of water and providing cups of water to residents. Staff were also advised by PBCFR and the Agency to relocate all residents to the common area around 8:45 PM to ensure appropriate supervision by facility staff and to prevent any residents from further heat exposure in the remaining upper floors. Class I	A 025		
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	A 030		

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A 030	Continued From page 8	A 030		

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 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

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A 030	Continued From page 9 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 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	A 030		

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A 030	Continued From page 10 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. (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	A 030		

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A 030	Continued From page 11 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 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	A 030		

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A 030	Continued From page 12 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 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 Hotline operated by the Department of Children and Families, and , 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 , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and	A 030		

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A 030	Continued From page 13 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 interview, it was determined that, the facility failed to ensure Resident's rights were maintained by failing to maintain a safe living environment; and neglecting to timely implement safety procedures (i.e. hydration carts/stations, resident temperature monitoring and possible evacuation of resident), for 42 Residents (Residents #1-#42) following an emergency in which the facility's Air Conditioner (A/C) was not fully functioning to keep the facility below 81 degrees Fahrenheit(F). The facility failure was a direct result of the facility receiving an immediate Cease and Desist order to evacuate all 42 residents within the facility. The findings Included: A) The facility was a four-story building that has approximately 42 residents, in addition, the facility had a common area/dining area located on the 1st floor. The facility 's cooling air sources were split between central air conditioning (A/C) and portable wall units. The 1st, 3rd, and 4th floor rooms were controlled by a central A/C and the 2nd floor rooms were controlled by individual window units.	A 030		

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	AL11965581	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 030	Continued From page 14 The facility's floor plan revealed the following information: 1st floor- 6 rooms, 10 residents resided on this floor 2nd floor-12 rooms, 15 residents resided on this floor 3rd floor- 6 rooms, 9 residents resided on this floor 4th floor- 6 rooms, 8 residents resided on this floor A review of the National Weather Service website documented outside temperatures for and were registered between 95 and 100 degrees. Additional review of the prior 2 weeks revealed similar temperature ranges. On at 8:50PM Palm Beach County Sheriff's Office (PBSO) responded to an altercation between residents (Resident#1 & # 2) at the facility. PBSO, upon arriving on scene, discovered the building was hot. Due to the extreme temperatures of the building, PBSO contacted the local fire department for further evaluation of the temperatures within the building. The Fire Marshal and Palm Beach County Fire Rescue (PBCFR) arrived to the scene to further investigate the temperature concerns. PBSO were also summoned by other residents at the time of their visit regarding the extreme heat temperatures. Upon arrival of the local Fire Rescue on at approximately 9 PM, their investigation found that multiple rooms (14 rooms) were identified as having temperature readings above 81 degrees Fahrenheit(F). The Administrator was ordered to evacuate the residents in those rooms above 81 F to other	A 030		

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A 030	Continued From page 15 areas/rooms in the facility with appropriate temperature (below 81 F). The local fire department, due to the extreme temperature within the building, remained on-site. PBCFR issued a Cease and Desist order for these rooms. On at 12:15 AM (effective date and time), Palm Beach County Fire Rescue issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. The following rooms are to be vacated: 101, 100, 104, 201, 203, 204, 205, 208, 209, 210, 212, 408, 410, 407, 412. The Administrator, after Palm Beach County Fire Rescue intervened, was able to get the temperature below 81 F for the following , 410, 412, 407. However, the Administrator was unable to bring the additional rooms as listed in the cease order to temperatures below 81 F. Therefore, the Cease and Desist order remained in place. On at approximately 12:45 PM, conducted by the Agency for Healthcare at approximately 12:45 PM, upon entering the first floor of the facility (main entrance area) temperatures were noted to be extremely hot. The temperature readings were recorded as 83 degrees Fahrenheit. It was observed that the exhaust vents located in the first-floor common area were not yielding air; hot air was coming out of all vents (4 total). An additional tour of the building revealed all floors (2nd-4th floor) were extremely warm including the stairwells for each floor. Based on additional observations, the	A 030		

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A 030	Continued From page 16 stairwells were used regularly by residents to go between floors due to the building only having 1 elevator. The elevator was also noted to be extremely hot. Further observations revealed that the facility's Administrator had not followed the order as issued on at 12:15 AM and allowed residents to use rooms (204, 205, 208, 210 and 212) that were ordered to be evacuated by the Fire Rescue. This placed the residents in danger due to extreme heat exposure. During an interview with the Administrator at 1:25PM, he was questioned regarding the occupancy of the rooms (204, 205, 208, 210 and 212) that were ordered to be evacuated by the cease order on at 12:15 AM. He stated that he thought he could use the rooms since he had fixed the individual wall units in the rooms. He was also asked if he had obtained permission from PBCFR to reoccupy those rooms, he stated "No". At this time, he stated that he would immediately move the residents to other rooms. He was asked how he planned to ensure that the rooms were not reoccupied. The Administrator and the Office Manager stated they would lock the doors and place a signage on the door that stated, "Do Not Use". During confidential resident interviews conducted on and between 12:45 PM through 12:00 AM, residents confirmed that the facility's A/C was not working correctly and that the facility was constantly hot a few weeks prior. Residents voiced concerns about the temperatures in the building being extremely uncomfortable and they were unabe to sleep due to the temperatures. Some residents also stated that they would have to sit outside to cool off. It was revealed that the Administrator and staff	A 030		

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A 030	Continued From page 17 were informed of these problems, and they stated that they are working on it. On at 2:59 PM, PBCFR investigators arrived for reinspection and additional monitoring due to the Cease order issued at 12:15 AM on . The investigators and the Surveyor toured the facility and identified that the temperatures in the facility had started to fluctuate. Temperature readings ranged from 78F to 91 F on the various floors, temperatures were not stable. Additional observations of the building on revealed as the afternoon and evening hours approached (3 PM -5 PM), the temperatures throughout the building increased tremendously. At 5:00 PM on , the temperatures were above 81 degrees and the Fire Department ordered the Provider (the Administrator) to close the fourth floor due to unsafe temperatures and relocate the residents to other floors within the facility. Throughout this period multiple residents in the building were seen seeking areas to cool off. Some of the residents were seen with their upper body clothing wet due to them sweating profusely from the extreme heat within the building. Many of the residents were sitting outside and some even attempted to come into the Administrator's office, that had a separate a/c system from the entire building (mini split air conditioning system).This system only cooled the Administrator's office. On at approximately 6:45 PM the PBCFR issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to	A 030		

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A 030	Continued From page 18 order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. Entire Facility/Occupancy. Even after the final Cease and Desist Order was issued, the temperatures within the building still remained unstable, which resulted in the building remaining extremely hot and multiple areas in the building and residents' rooms had temperature readings above 81F. Residents still observed sweating profusely and seeking cooler locations within the building. A review of the facility's grievance log revealed multiple residents complaining about the facility air conditioning system and the extreme heat in the building since . Multiple confidential resident interviews conducted on revealed the facility was extremely hot for weeks and the A/C was not working. The residents stated that they had informed staff on duty and the Administrator on multiple occasions (prior to) regarding the A/C not working and the building being extremely hot resulting in them also being hot. During an interview with the Administrator on at 1:15 PM, a request was made to provide documentation on prior repairs to the A/C unit and new purchases for any window units for the facility. The Administrator stated he would provide the information; however, no documentation was provided. The Administrator stated he had the facility's maintenance worker working on the units prior to and that he maintained wall units in an offsite storage unit. However, he still was unable to provide documentation of any prior intervention to resolve the a/c problems within the facility.	A 030		

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A 030	Continued From page 19 The Residents (42 in total) were exposed to extreme heat within the building resulting in an environment that placed them at risk for heat exhaustion or other heat related issues for an extended period of time on and . An additional record review revealed the residents had endured the extreme heat and a/c (including window units) weeks prior to the incident on . B) Due to the immediate required evacuation of all 42 residents on , the Provider failed to ensure the immediate transfer of their personal belongings (clothing and personal hygiene items) in a timely manner. On and , the Agency was notified by telephone and interviews conducted with residents (during monitoring visits at the receiving facilities) and receiving facilities regarding the residents' personal belongings not being delivered. During an interview with the Administrator on at 1:00 PM, he stated that the Office Manager and other staff were going to the facility on to pack up all the residents' personal belongings and would ensure that all items were delivered to the receiving facilities. The Provider failed to make attempts in a timely manner to ensure residents had their belongings transferred to the other facilities, some residents were without their personal belongings for three (3) or four (4) days. Class I	A 030		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators	A 077		

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A 077	Continued From page 20 429.176 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 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:	A 077		

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A 077	Continued From page 21 1. Be at least ; 2. If employed on or after , 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 , 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 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: 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	A 077		

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A 077	Continued From page 22 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: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that it was under the supervision of an Administrator who	A 077		

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A 077	Continued From page 23 was responsible for the operation and maintenance of the facility for 42 Residents (Resident #1-#42). The facility also was without the direction and supervision of an Administrator or Designee on and during an emergency in which the facility air conditioning system was not fully functioning to keep the facility below 81 degrees Fahrenheit(F). As a result of this emergency, an immediate Cease and Desist order implemented by the Fire Marshal on required the entire building to be evacuated, affecting all 42 residents. The findings included: The following events occurred at the facility under the operation and maintenance of the current Administrator. These events immediately jeopardized the safety and the well-being of the residents, resulting in the facility being issued an Emergency Cease and Desist order and the relocation of all residents (42). The Administrator failed to implement safety procedures to monitor residents during an emergency identified on and . A) The Administrator was noted to be extremely , during the emergency identified by local Fire Rescue and the local Sheriff's Office on . Upon notification from emergency services and law enforcement at 8:50PM, the Administrator had no urgency for arrival to the facility, which delayed the start of further assessment of air conditioning concerns and emergency procedures. The Administrator did not arrive on scene until nearly one hour after being contacted. Upon arrival, the Administrator remained , with the assisting emergency personnel that were onsite at the	A 077		

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A 077	Continued From page 24 facility due to the extreme heat temperatures that were identified in the building. B) On at 8:50PM Palm Beach County Sheriff's Office (PBSO) responded to an altercation between residents (Resident#1 & # 2) at the facility. PBSO, upon arriving on scene, discovered the building was hot. Due to the extreme temperatures of the building, PBSO contacted the local fire department for further evaluation of the temperatures within the building. The Fire Marshal and Palm Beach County Fire Rescue (PBCFR) arrived at the scene to further investigate the temperature concerns. PBSO were also summoned by other residents at the time of their visit regarding the extreme heat temperatures. Upon arrival of the local Fire Rescue on , their investigation found that multiple rooms (14 rooms) were identified as having temperature readings above 81 degrees Fahrenheit(F). The Administrator was ordered to evacuate the residents in those rooms above 81 F to other areas/rooms in the facility with appropriate temperature (below 81 F). The local fire department, due to the extreme temperature within the building, remained on-site. PBCFR issued a Cease and Desist order for these rooms. On at 12:15 AM (effective date and time), Palm Beach County Fire Rescue issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. The following rooms are	A 077		

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A 077	Continued From page 25 to be vacated: 101, 100, 104, 201, 203, 205, 208, 209, 212, 408, 410, 407, 412. The Administrator, after Palm Beach County Fire Rescue intervened, was able to get the temperature below 81 F for the following , 410, 412, 407. However, the Administrator was unable to bring the additional rooms listed in the cease order to temperatures below 81 F. Therefore, the Cease and Desist order remained in place. During a tour of the facility on , conducted by the Agency for Healthcare at approximately 12:45 PM, upon entering the first floor of the facility (main entrance area) temperatures were noted to be extremely warm. The temperature readings were recorded as 83 degrees Fahrenheit. It was observed that the exhaust vents located in the first-floor common area were not yielding air; hot air was coming out of all vents (4 total). An additional tour of the building revealed all floors (2nd-4th floor) were extremely warm including the stairwells for each floor. Based on additional observations, the stairwells were used regularly by residents to go between floors due to the building only having 1 elevator. The elevator was also noted to be extremely hot. Further observations revealed that the facility's Administrator had not followed the order as issued on at 12:15 AM and allowed residents to use rooms (204, 205, 208, 210 and 212) that were ordered to be evacuated by the Fire Rescue. This placed the residents in danger due to extreme heat exposure. During an interview with the Administrator at 1:25 PM, he was questioned regarding the occupancy of the rooms (204, 205, 208, 210 and 212) that were ordered to be evacuated by the cease order on at 12:15 AM. He stated that he thought he could use	A 077		

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A 077	Continued From page 26	A 077		

the rooms since he had fixed the individual wall units in the rooms. He was also asked if he had obtained permission from PBCFR to reoccupy those rooms, he stated "No". At this time, he stated that he would immediately move the residents to other rooms. He was asked how he planned to ensure that the rooms were not reoccupied. The Administrator and the Office Manager stated they would lock the doors and place a signage on the door that stated, "Do Not Use".

During confidential resident interviews conducted on between 12:45 PM through 12:00 AM, residents confirmed that the facility's A/C was not working correctly and that the facility was constantly hot a few weeks prior. Residents voiced concerns about the temperatures in the building being extremely uncomfortable and they were unable to sleep due to the temperatures. Some residents also stated that they would have to sit outside to cool off. It was revealed that the Administrator and staff were informed of these problems, and they stated that they are working on it (the a/c).

Additional observations of the building revealed as the afternoon and evening hours approached (2:00 PM -5:00 PM), the temperatures throughout the building increased tremendously. At 5:00 PM on , the temperatures were above 81 degrees, and the Fire Department ordered the Provider (the Administrator) to close the fourth floor due to unsafe temperatures and relocate the residents to other floors within the facility. Throughout this period multiple residents in the building were seen seeking areas to cool off. Some of the residents were seen with their upper body clothing wet due to them sweating profusely from the extreme heat within the building. Many

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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 077	Continued From page 27 of the residents were sitting outside and some even attempted to come into the Administrator's office, that had a separate a/c system from the entire building (mini split air conditioning system). This system only cooled the Administrator's office. On at approximately 6:45 PM the PBCFR issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. Entire Facility/Occupancy. C) A review of the facility's grievance log revealed multiple residents complaining about the facility air conditioning system and the extreme heat in the building since . Multiple confidential resident interviews conducted on revealed the facility was extremely hot for weeks and the A/C was not working. The residents stated that they had informed staff on duty and the Administrator on multiple occasions (prior to) regarding the A/C not working and the building being extremely hot resulting in them also being hot. Although the Administrator was aware of the problem, there was no prior facility intervention to eliminate the problem before the events arose to imminent danger. D) The Administrator still was unable to implement the facility CEMP effectively immediately without the intervention of the Senior Planner, the Fire Marshal, PBSO and the Agency. The Administrator was unable to effectively implement his mutual aid agreement component	A 077		

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A 077	Continued From page 28	A 077		

of the CEMP during the final emergency cease and desist ordering the removal of all residents (42). A review of the facility's mutual aid agreement revealed it was established to provide temporary emergency shelter in the event of a forced evacuation and was a commitment between both parties to comply with all state and local rules regarding disaster preparedness.

The Administrator was unable to secure transportation with the transportation company listed in the CEMP. The Administrator contacted the transportation company around 7:00 PM on , and due to contractual problems, the facility was unable to utilize the company to transport the residents to other facilities. The facility was only able to utilize 1 out of 2 mutual aid facilities (transfer facilities listed in the CEMP). The facility was only able to transfer 10 residents to the facility's sister facility. As the facility only had 1 minivan to utilize, which was being used to transport the 10 residents to the sister facility located in West Palm Beach (over 10 miles north of the facility). The transport required 2 trips as the van could not accommodate all residents at once. This resulted in the urgency to place the remaining 32 residents, in which the facility Administrator had to spend over 2 hours contacting various facilities for bed availability. The Administrator failed to communicate to the receiving facilities that the Provider needed assistance with transportation. The receiving facilities upon arrival on to evaluate residents for potential placement had to also provide transportation to the residents. This led to an additional delay for the already overheated and residents who were awaiting evacuation.

E) On , the PBCFR conducted a

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A 077	Continued From page 29 follow-up investigation based on additional violations identified during the emergency call conducted on and . This emergency call resulted in the facility being issued a Cease and Desist Order (twice in the small day). A review of the inspection report dated documented multiple facility violations regarding the operation and the maintenance of the facility. Further review of this inspection revealed major concerns regarding the facility's electrical system and HVAC (Heating, , and Air Conditioning) systems. The inspection report mandated the facility hire a licensed professional to further evaluate the facility's HVAC and electrical systems due to safety concerns identified in the and emergencies. The facility cease order remained in effect based on the inspection that occurred on . The previously stated events reflected the facility's Administrator failure to maintain and operate the building in an efficient manner to ensure resident safety and well-being in the facility. This failure placed the entire resident census (42 out of 42 residents) in immediate jeopardy. Class I	A 077		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;	A 152		

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A 152	Continued From page 30 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a safe living environment and to ensure that all mechanical and electrical systems were properly maintained in good working order. The facility also failed to	A 152		

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A 152	Continued From page 31 timely repair/or replace mechanical/or electrical issues. This affected the entire resident census of 42 residents. The facility failure to maintain a safe environment on and resulted in the facility receiving an immediate Cease and Desist order for the entire facility requiring the evacuation of all residents. The findings included: The facility was a four-story building that has approximately 42 residents, in addition, the facility had a common area/dining area located on the 1st floor. The facility 's cooling air sources were split between central air conditioning (A/C) and portable wall units. The 1st, 3rd, and 4th floor rooms were controlled by a central A/C and the 2nd floor rooms were controlled by individual window units. The facility's floor plan revealed the following information: 1st floor- 6 rooms, 10 residents resided on this floor 2nd floor-12 rooms, 15 residents resided on this floor 3rd floor- 6 rooms, 9 residents resided on this floor 4th floor- 6 rooms, 8 residents resided on this floor On at 8:50 PM Palm Beach County Sheriff's Office (PBSO) responded to an altercation between residents (Resident#1 & # 2) at the facility. PBSO, upon arriving on scene, discovered the building was hot. Due to the extreme temperatures of the building, PBSO contacted the local fire department for further evaluation of the temperatures within the building. The Fire Marshal and Palm Beach County Fire	A 152		

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A 152	Continued From page 32 Rescue (PBCFR) arrived to the scene to further investigate the temperature concerns. PBSO were also summoned by other residents at the time of their visit regarding the extreme heat temperatures. Upon arrival of the local Fire Rescue on , their investigation found that multiple rooms (14 rooms) were identified as having temperature readings above 81 degrees Fahrenheit(F). The Administrator was ordered to evacuate the residents in those rooms above 81 F to other areas/rooms in the facility with appropriate temperature (below 81 F). The local fire department, due to the extreme temperature within the building, remained on-site. PBCFR issued a Cease and Desist order for these rooms. On at 12:15 AM (effective date and time), Palm Beach County Fire Rescue issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. The following rooms are to be vacated: 101, 100, 104, 201, 203, 204, 205, 208, 209, 212, 408, 410, 407, 412. The Administrator, after Palm Beach County Fire Rescue intervened, was able to get the temperature below 81 F for the following , , , 410, 412, 407. However, the Administrator was unable to bring the additional rooms as listed in the cease order to temperatures below 81 F. Therefore, the Cease and Desist order remained in place. On at 12:45 PM, upon entering the	A 152		

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A 152	Continued From page 33 first floor of the facility (main entrance area) temperatures were noted to be extremely warm. The temperature readings were recorded as 83 degrees Fahrenheit. It was observed that the exhaust vents located in the first-floor common area were not yielding air; hot air was coming out of all vents (4 total). An additional tour of the building revealed all floors (2nd-4th floor) were extremely hot including the stairwells for each floor. . On at 2:59 PM , PBCFR investigators arrived for reinspection and additional monitoring due to the Cease order issued at 12:15 AM on . The investigators and the Surveyor toured the facility and identified that the temperatures in the facility had started to fluctuate. Temperature readings ranged from 78F to 91 F on the various floors, temperatures were not stable. Additional observations at 2:59 PM of the building revealed as the afternoon and evening hours approached (3 PM -5 PM), the temperatures throughout the building increased tremendously. At 5:00 PM on , the temperatures were above 81 degrees and the Fire Department ordered the Provider (the Administrator) to close the fourth floor due to unsafe temperatures and relocate the residents to other floors within the facility. Throughout this period multiple residents in the building were seen seeking areas to cool off. Some of the residents were seen with their upper body clothing wet due to them sweating profusely from the extreme heat within the building. Many of the residents were sitting outside and some even attempted to come into the Administrator's office, that had a separate a/c system from the entire building (mini split air conditioning system).This system only cooled the	A 152		

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A 152	Continued From page 34 Administrator's office. On at 5 PM, the PBCFR ordered the Provider to close the entire 4th floor and relocate the residents to other floors within the facility due to the unsafe temperatures above 90 degrees Fahrenheit. On at approximately 6:45 PM the PBCFR issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. The Entire Facility/Occupancy. Even after the final Cease and Desist Order was issued, the temperatures within the building still remained unstable, which resulted in the building remaining extremely hot and multiple areas in the building and residents' rooms had temperature readings above 81F. Additional observations of the outside parameter of the facility, loud rattling noises were heard from various wall units on the second floor. The A/C units presented signs instability in their operation due the consistent harsh rumbling noises. A review of the facility's grievance log revealed multiple residents complaining about the facility air conditioning system and the extreme heat in the building since . Multiple confidential resident interviews conducted on revealed the facility was extremely hot for weeks and the A/C was not working. The residents stated that they had informed staff on duty and	A 152		

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A 152	Continued From page 35 the Administrator on multiple occasions (prior to) regarding the A/C not working and the building being extremely hot resulting in them also being hot. During an interview with the Administrator on at 1:15 PM, a request was made to provide documentation on prior repairs to the A/C unit and new purchases for any window units for the facility prior to and in which Agency intervention was implemented. The Administrator stated he would provide the information; however, no documentation was provided. The Administrator stated he had the facility's maintenance worker working on the units prior to and that he maintained wall units in an offsite storage unit. However, he still was unable to provide documentation of any prior invention to resolve the a/c problems within the facility. On at approximately 12:20 AM, during an interview with the Fire Investigator, he stated that the facility had previously implemented partial repairs to the air conditioning system which is inadequately sized and needs a complete replacement, additonal installation, and electrical work. The current unit is inadequate to properly cool the building to safe temperatures for residents. B) On , the PBCFR conducted a follow-up investigation based on additional violations identified during the emergency call conducted on and . This emergency call resulted in the facility being issued a Cease and Desist Order (twice in the same day). Review of the inspection report dated documented the following 19	A 152		

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A 152	Continued From page 36 concerns: 1) Minimum 36" Front Clearance Action required: Provide required 36 inches of clearance in front of electrical control panels. 2) Continuously maintained- Device, Equipment, System Action Required: Repair or replace , exit signs 3) Requirement for an Electrical Safety Evaluation Inspector Comments: Where the AHJ determines that there is sufficient evidence that existing electrical wiring, fixtures, appliances, or equipment is potentially unsafe, the AHJ is authorized to require an evaluation of the existing electrical wiring, fixtures, appliances, or equipment, or portion thereof, by a qualified person. Action required: After a qualified person evaluates the existing electrical system, the owner must submit an assessment report to the AHJ. This report must detail the condition of the electrical wiring, fixtures, appliances, and equipment, along with recommendations for any necessary repairs to address unsafe conditions. 4) Open electrical Boxes, in Panel Inspector Comments: All panelboard and switchboards, pull boxes, junction boxes, switches, receptacles, and conduit bodies shall be provided with covers compatible with the box or conduit boy construction and suitable for the conditions of use. Action required: All open spaces in the electrical panel box shall have the proper cover/blank breaker Action required: Replace the missing or damaged switch plate cover. 5) Junction and Electrical outlet boxes Inspector comments: Open junction boxes and	A 152		

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A 152	Continued From page 37 open wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. Action required: Eliminate all open wiring splices. All exposed wiring shall be covered. 6) Multiplug Adapters shall not be used as a substitute for permanent wiring or receptacles. Action Reuired: Plug appliances directly into permanently installed receptacles. 7) Required Permits shall comply with Chapter 13 Fire Protection Systems (Section 1.12) Action required: Permit #23- 1035, for replacement of the fire alarm system, requires a final inspection by the fire department to complete the permit process. The last inspection dated , was a partial fire alarm test and several items that needed to be addressed. 8) System and Equipment Test & Maintenance Records Action required: Firm Alarm Logbook must be updated to reflect the following requirements: a) Log Sheet -Records each time someone performs maintenance or service on the system -Include date, company/service person, reason for visit, and results of inspection as per documentation b) NFPA Record of Completion Form c) Inspection Records D. Service Records E. As Built Drawings F. Third Party Certification 9) No furnishings, Decorations, or other objects shall obstruct exits or egress therefrom, or visibility thereof Action required: Remove furnishings, decorations or other objects obstructing exits. Action required: Ensure locks do not require the use of a key, tool, or special knowledge or effort from the egress side of the door.	A 152		

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A 152	Continued From page 38 10) Smoking regulations shall be adopted by the administration Inspector comments: Smoking regulation shall be adopted by the administration of board and care occupancies. -Smoking should be prohibited in any room, compartment, or area where flammable or combustible liquids combustible gases, or is used or stored and in any other hazardous location. Action required: Cigarettes and cigars were observed discarded across the property grounds in excess. No designated smoking areas, ashtrays, or required signage were found in accordance with adopted smoking regulations. Must clearly identify and maintain areas where smoking is prohibited, provide noncombustible ashtrays of safe design in all permitted smoking areas, and ensure safe closing the , calls are available for disposal of smoking material. Additionally smoking materials shall not be provided to or maintained by residents without administrative approval, and residents who are not responsible with regard to safe smoking practices must not be permitted to smoke unless directly supervised this policy shall be strictly enforced 11) Remove Combustible Waste Creating Fire Hazard Action required: Remove combustible waste that is potentially creating a fire hazard. 12) Internal Obstruction inspection required Action required: Have fire sprinkler company conduct the required five-year internal obstruction inspection. 13) Existing Residential Board and Care Occupancies- Inspector Comments: The administration of every residential board and care facility shall have, in effect and available to all supervisory personnel,	A 152		

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A 152	Continued From page 39 written copies of a plan for protecting all persons in the event of a fire, for keeping persons in place, for evacuating persons to areas of refuge and for evacuating persons from the building when necessary. Action required: The CEMP/Fire Plan on site was missing the evacuation map and has expired. The last review by PBCFR was . Must submit plans for review. 14) Electrical Disconnect shall be legibly marked Action required: each disconnecting means shall be legibly marked."Generator Emergency Stop" or "Generator Emergency Shutdown" . 15) New Electrical Installations per NFPA 70 Action required: Repair the electrical panel door and remove the strap tie that prevents entry into the panel. Action required: Must provide a cover to protect the exposed lights within the enclosure. 16) Pull stations shall be accessible Action required: Remove all obstructions blocking the visibility and/or accessibility of manual fire alarm boxes. 17) ⌄ or Heat-Producing Equipment Inspector comments: ⌄ or heat-producing equipment shall be in accordance with NFPA 31, NFPA 54, NFP A70, NFPA 91, or NFP A211, as applicable unless such installations are approved existing installations, which shall be permitted to be continued in service. Action required: Must have HVAC system some duct work evac evaluated by a licensed HVAC contractor for proper installation and compliance with all applicable codes. 18) All Fire Protection Systems are in Operating Condition Action required: (Fire alarm) Must replace all missing smoke detectors within the sleeping rooms. 19) Stair treads and landings shall be free of	A 152		

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A 152	Continued From page 40 projections or , that could trip stair users. Action required: Must repair the means of egress for the 3rd and 4th floor residents that are exiting onto the 2nd floor roof, at the top of the stair landing. There is a , that is creating a tripping hazard. Class I	A 152		
A 182	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure that they maintained a copy of their Comprehensive Emergency Management Plan (CEMP) on site at the facility and readily available for review and implementation, in the event of an emergency. The findings included: A copy of the facility's CEMP approval letter provided by the Emergency Management division revealed it was approved until . Although the facility's CEMP was approved, the facility had no active knowledge on the	A 182		

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A 182	Continued From page 41	A 182		

implementation of this plan in the event of an emergency. An emergency occurred at the facility on in which the air temperature throughout (resident rooms, common areas, hallways) had risen above 81 degrees(F) due to the failure of the facility's air conditioning system. At this time, the facility census was 42 residents, placing all residents in immediate danger and exposed them to extreme heat within the building resulting in an environment that placed them at risk for heat exhaustion and other heat related issues.

On around 8:50 PM local enforcement was contacted by a resident via 911 due to an altercation. Upon arrival of law enforcement (PBSO), extreme heat temperatures were observed, and the local Fire Marshal was contacted. Palm Beach County emergency response and local sheriff department (PBSO) were notified and arrived at the facility to address the issue.

The local Fire Department (PBCFR) rescue found 14 rooms within the facility had temperature readings exceeding 81 degrees. As a result, the Fire Marshal was contacted and arrived onsite to work with the Administrator on a resolution. However, the Administator was , and unable to locate his Comprehensive Emergency Management Plan and/or implement an emergency plan to counteract the extreme heat temperatures in the building. The Palm Beach County Duty Officer for Emergency Management was contacted around 10:35 PM regarding the facility and asked about their CEMP.

At 11:54 PM on , the Senior Planner arrived to assist and offer support with the

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 _____	06/11/2025

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 182	Continued From page 42 facility's Comprehensive Emergency Management Plan. On , the Senior Planner from the County's Emergency Management Office assisted the Administrator and the Designee Administrator, who were not helpful and not , with CEMP. Neither employee was able to produce a copy of the CEMP, nor were they aware of the proper procedure for plan implementation. The Senior Planner accessed a copy of the facility's CEMP using the county's internal electronic system with the county. The Provider failed to take any protective measures, provide residents with adequate hydration, provide hydration stations and conduct individual temperature checks of the residents. On at 12:15 AM (effective date and time), Palm Beach County Fire Rescue issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. The following rooms are to be vacated: 101, 100, 104, 201, 203, 204, 205, 208, 209, 212, 408, 410, 407, 412. The Administrator, after Palm Beach County Fire Rescue intervened, was able to get the temperature below 81 F for the following , , , 410, 412, 407.However, the Administrator was unable to bring the additional rooms as listed in the cease order to temperatures below 81 F. Therefore, the Cease and Desist order remained in place. Due to the persistent heat temperatures	A 182		

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 _____	06/11/2025

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CREST MANOR	504 THIRD AVENUE SOUTH LAKE WORTH, FL 33460

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A 182	Continued From page 43 throughout the building in the afternoon and evening hours on . On at approximately 6:45 PM the PBCFR issued a "Cease and Desist by Order of the Fire Marshal". Review of this order revealed the following: You are hereby ordered to stop all work, business or sale. The AHJ (Authorities Having Jurisdiction) shall have the authority to order an operation, construction, or use stopped when any of the following exist: (c) an imminent danger to life and safety has been created. The Entire Facility/Occupancy. At this time, the Administrator still was unable to implement the facility's CEMP effectively immediately without the intervention of the Senior Planner, the Fire Marshal, PBSO and the Agency. The Administrator was unable to effectively implement his mutual aid agreement component of the CEMP during the final emergency cease and desist ordering the removal of all residents(42). A review of the facility's mutual aid agreement revealed it was established to provide temporary emergency shelter in the event of a forced evacuation and was a commitment between both parties to comply with all state and local rules regarding disaster preparedness. The Administrator was unable to secure transportation with the transportation company listed in the CEMP. The Administrator contacted the transportation company around 7PM on , and due to contractual problems, the facility was unable to utilize the company to transport the residents to other facilities. The facility was only able to utilize 1 out of 2 mutual aid facilities (transfer facilities listed in the CEMP). The facility was only able to transfer 10 residents to the facility's sister facility. As the facility only had 1 minivan to utilize, which was	A 182		

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 _____	06/11/2025

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A 182	Continued From page 44 being used to transport the 10 residents to the sister facility located in West Palm Beach (over 10 miles north of the facility). The transport required 2 trips as the van could not accommodate all residents at once. This resulted in the urgency to place the remaining 32 residents, in which the facility Administrator had to spend over 2 hours contacting various facilities for bed availability. The Administrator failed to communicate to the receiving facilities that the Provider needed assistance with transportation. The receiving facilities upon arrival on to evaluate residents for potential placement had to also provide transportation to the residents. This led to an additional delay for the already overheated and residents who were awaiting evacuation. Class I	A 182		