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
	AL11965951	A. BUILDING: _____ B. WING _____	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENCREST ALF III	4471 COCONUT CREEK BLVD COCONUT CREEK, FL 33066

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A 000	Initial Comments An unannounced Complaint investigation, complaint #2025018166 was conducted at Havencrest ALF III from /2025. The facility had deficiencies at the time of the survey.	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 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		

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 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 the level of care, services and appropriate oversight required to meet the needs of the residents. This was evidenced by the failure to assess and respond timely to a significant change in condition for 1 of 1 sampled resident's (Resident #1) who required emergency evaluation and transfer to the hospital. The findings include: Review of Resident #1's Resident Health Assessment form 1823 dated indicated the resident had the following medical diagnosis'	A 025		

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including , 's , ( ), , Ankylosing , , , , Prostatic Hyperplasia ( ) and , , . Under physical limitations section indicated stiffness of the , , and able to transfer with one person assistance, prefers to be by himself and can be in bed if requests. Review of / behavioral status section indicated Resident #1 was alert and oriented, forgetful. Resident #1 requires daily oversight with family providing private duty aides (PDA). The resident was assessed as independent for eating. He required assistance with Activities of Daily Living (ADL) including ambulation, bathing, , self-care, toileting, transferring and with self-administration of medications. He was assessed to require a regular diet.

Review of the facility admission/discharge log indicated Resident #1 was admitted on .

Review of the facility progress notes for Resident #1 dated indicated the resident required one person assistance for ADL care. The note revealed the resident was able to feed himself and make his needs known. The resident was admitted with personal private duty aides who would stay with the resident from morning until 3 PM daily, including weekends.

Review of the facility progress notes for Resident #1 dated indicated the resident eats all his meals, feeds himself, PDA assists him with all meals. The resident prefers privacy and to be in his room but does socialize with other residents.

Review of the facility progress notes for Resident #1 dated indicated the resident has a

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care manager hired by the family. The resident is coherent, and can make his needs known, including food preferences. The note indicates that Resident #1 feeds himself, but PDA assists him, and he eats very slowly. The note indicated that when the PDA leaves at 3 PM, the facility staff get him out of his room, and he eats his dinner meal at the dining table. The note further indicates the facility staff allow Resident#1 time to eat his meal, served at 5 PM and he finishes around 5: 50 PM. The note indicates Resident #1's family provides snacks for him to eat as he wishes, and the facility is concerned about the resident's dietary intake prior to planned meals.

Review of the facility progress notes for Resident #1 dated indicated the resident choked on food as the PDA was feeding him. The PDA informs the Administrator that the resident all the food consumed and was "OK". The note indicates the Administrator notifies the care manager and physician.

Review of the facility progress notes for Resident #1 dated indicated that the Administrator "did not like how the resident looked, unusual for him to look this way." The resident tells the Administrator that his does not feel well. The note indicates 911 is called to transfer the resident to the hospital for evaluation.

Review of hospital records for Resident #1 dated indicated a chief complaint of , worsening with increased , and after aspirating on rice 2 days prior. Resident#1 was diagnosed with , left lower of the left . Further review of the hospital record indicated a Speech Language Evaluation which was

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A 025	Continued From page 4 conducted at the resident's bedside on . The evaluation recommendations included a regular diet and thin liquids with , precautions and swallow strategies, including small bites/ sips with slow rate. Resident#1 was discharged on . No facility progress notes were provided by the facility documenting Resident #1's return to the facility after hospitalization. Review of the facility progress notes for Resident #1 dated indicated Resident#1 PDA provides his usual care and assists with his breakfast. The note indicates the resident was transferred to the TV room and had a visitor. After the visitor leaves, Resident#1 started to , the amount is described as "small amount that fit in the palm of the facility caregiver's " and Resident#1 stated he was "OK". The note indicates Resident#1 requested to return to his room and the facility care giver and PDA transfer him to his bed. The note indicates that caregiver calls the Administrator to notify her that Resident#1 was not feeling well and had " a small amount." The note further indicates that the Administrator was on her way to the facility and requested the staff to open and use "Facetime" (a proprietary videotelephony product) to observe the resident. The note indicates that Resident #1 was sitting upright in bed at a 45-degree angle, staff were calling his name, and he answered but "quietly". The note indicates that this was not an unusual response for Resident#1. The Administrator instructed the staff to call 911 for evaluation and was taken to the hospital. The note further indicates the Administrator notifies Resident #1's care manager that she was on her way to the facility.	A 025		

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A 025	Continued From page 5 In an interview with Resident #1's private care manager on at 2:30 PM she stated that she was a licensed practical nurse (LPN) and was employed by Resident #1's family as the resident's care manager. She stated that she was responsible for the coordination and supervision of Resident #1's care needs. She stated Resident #1 had medical history including but not limited to , , of the , region which prevented the resident from turning his side to side or forward / backward. She stated that Resident#1 had limited range of motion over his entire body. She stated that he was unable to ambulate and required use of a wheelchair for mobility. She stated that Resident#1 was unable to perform ADL care for himself and the family had hired a PDA to complete care as needed. She stated that the resident was alert and oriented and was able to make his needs known. She stated that Resident#1 required assistance with eating from the PDA since the resident had difficulty lifting his arms to feed himself. The care manager stated that Resident#1 did not have a diagnosis of , , , and was able to eat a regular diet. She stated that the resident would not have been able to clear his and position himself if he choked on food due to his physical limitations. The care manager indicated that the resident was a full code status. The nurse care manager stated that on she was called by facility Staff #A to notify her that Resident #1 had after breakfast, and the PDA and Staff #A had returned him to his bed. The nurse stated she was informed that the resident responded to his name but was not speaking. She stated that Staff #A did not call 911 but was on the phone speaking with the Administrator. She stated that Staff #A informed her Resident #1's , , (O 2) Saturation (SAT)	A 025		

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A 025	Continued From page 6 reading was 67% (Normal O 2 SAT levels range 95-100% and a reading below 88% needs immediate medical attention) and he had a . The care manager stated that she was aware that a private mobile ( ) registered nurse (RN) hired to provide Resident #1 with hydration was enroute to the facility. She stated that the facility did not have any licensed medical personnel on staff. She stated that the mobile RN arrived at the facility, and assessed Resident#1. The RN reported that Resident #1 was unresponsive, had a O 2 SAT reading of 67%. The nurse care manager stated that the mobile RN questioned Staff #A if 911 had been called and if not, instructed her to call immediately. The care manger stated 911 rescue arrived and transported Resident#1 to the hospital for emergency evaluation/ treatment. She stated that Resident#1 required and was intubated for , , failure. The nurse stated that she was informed that on admission to the emergency room, was found on the resident's tube. In a follow-up interview with the care manager on at 4:15 PM she stated that Resident#1 had had a previous choking episode on while eating rice and was transferred to the hospital for evaluation. She stated Resident#1 returned to the facility on . She stated that Resident#1 had a bedside swallowing test completed and the test was negative for In an interview with the mobile RN on at 4 PM she stated that she is an independent contractor employed by a company that provides mobile treatments to patients. She stated that she had been hired to	A 025		

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provide hydration to Resident #1 every 2 weeks to combat , in the resident. She stated that she coordinated the treatments with Resident #1's nurse care manager. She stated that Resident #1 was alert and oriented, very friendly and she enjoyed speaking with him as he received his treatments. She stated that Resident#1 had a diagnosis of , , , which caused no range of motion in the resident's . She stated he could not turn his and could not bend at the waist. She stated that Resident#1 was able to move his extremities, but she never observed him feeding himself. She stated that he required assistance with drinking from a sippy cup and had a PDA to assist him during the day. She stated that on at approximately 9:23 AM, she received a text message from Resident #1's care manager who requested that she go to the facility to check on Resident #1. She stated she arrived at approximately 12 PM and met Staff #A at the facility door. She stated that Staff #A questioned her if Resident#1's care manager had texted her that "Resident #1 was not doing well and had stopped talking". She stated Staff #A told her Resident#1 had after breakfast. The RN stated that she entered the resident's room and observed Resident #1 lying in his hospital bed, with the of the bed elevated to 20 degrees. The nurse stated that she observed Resident #1 with a , , canula in place, his , were closed and his was open. She stated she instructed Staff #A to turn the down to 3 liters (L)/minute and recalls Staff #A informed her the resident's SAT reading was 60. She stated she never saw a , device at the facility. The nurse stated that the PDA informed her that Resident #1 had told her that morning he was not feeling well and asked if he was going to the doctor. The nurse stated that the PDA did not

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A 025	Continued From page 8 notify anyone of Resident#1's complaint. At 12:13 PM the nurse attempts to take Resident #1's radial , and cannot feel a , . She stated Resident #1's , reading was 34 beats/ minute, , ( ) , , were 8/minute and SAT 67%. She stated there was no noted on the resident's , , his skin was warm and his pupils were equal and reactive. She stated she attempted to do a sternal rub, and Resident #1 was not responding. At 12:15 PM she stated she instructed Staff #A to call 911. She stated both PDA and Staff #A appeared frozen and didn't respond initially. At approximately 12:17PM she stated she questioned Staff #A if Resident#1 had a " " ( ). and Staff #A and the PDA both responded, they did not know the code status. She stated Staff #A left the room and while attempting to gather Resident #1's medical information for the emergency crew arrival. The RN stated that she texted the care manager at 12:20PM about orders and at 12:21PM the care manager called to informed her that Resident#1 was a full code. The RN stated that she kept her on Resident #1 feeling for his , ,yet never had to perform , , . The RN confirmed she had arrived at the facility at 12noon and began to assess the resident, she was unsure of the actual time that 911 arrived. The RN stated she was not sure who had called 911 but she believed Staff # A waited for the Administrator to direct her to call 911. The RN stated that the Administrator was not on site during the incident. Review of the facility staffing schedule for indicated Staff #A was scheduled to work 7A-7P along with the Administrator, who was also scheduled 7A-7PM.	A 025		

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A 025	Continued From page 9 In an interview on at 9AM with Resident#1's PDA she stated she was employed by the resident's family and had worked with Resident #1 for approximately 2 weeks, hours 7:30AM - 12:30PM. She stated that her responsibilities included proving assistance to Resident#1, including bathing, , and eating. She stated she assisted him to eat his meals since he was unable to feed himself. She stated that Resident #1 needed to be fed slowly. She stated the resident was able to make his needs and wishes known. She stated Resident#1 was unable to turn his body but could turn his and bend from his waist. She stated that on the morning of she assisted Resident#1 with his breakfast and got him bathed and dressed. She stated that he told her that he "didn't feel good and asked her if she was taking him to the doctor?" She stated she told him she didn't know. The PDA stated a family member came to visit the resident and Resident#1 informed the family member he was not feeling well and was told to stay in bed. The PDA stated that after the family visit, she brought Resident#1 to the TV room and positioned him in a recliner chair. She stated he was speaking normally, "talking good". She stated that she left him briefly to prepare her breakfast and then returned to his side. She stated that Resident#1 observed that she was eating, a biscuit/cookie and he requested one and she gave him one. The PDA stated that Resident#1 choked, she elevated the of the recliner and then he small amount of . She stated that the Resident#1 did not look good and was not talking. The PDA stated she instructed Staff #A to call 911, but she did not. The PDA stated Staff #A told her, "She needed to speak with the Administrator". The PDA stated she and Staff #A	A 025		

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moved Resident#1 to his wheelchair then into his bed. She stated that Staff# A was taking the resident's and told her it was "OK", but she stated she didn't believe her. When questioned about if was available and who applied it, she stated Staff #A applied a mask and it was connected to a "green tank." The PDA stated that she attempted to enforce the urgent need to call 911 but Staff# A was on phone with Administrator. The PDA stated that the RN arrived and instructed Staff #A to turn down the flow. The PDA stated that Resident #1's were open, but he was not speaking. She stated that the RN instructed Staff# A to call 911, and when rescue arrived Resident #1 was transported to the hospital for evaluation.

In an interview with facility Staff #A on at approximately 8:45AM she stated that she was a home health aide, and she had no nursing license. She stated that she works at the facility two days a week and works at a sister facility the other days. When asked if she knew where to find a resident medical record, specifically the requested code status, she stated that she wasn't sure but would ask the Administrator. She stated that the Administrator was knowledgeable about all residents' code status so she could call her if necessary. Staff #A stated she was on duty on . She stated that the Administrator was also scheduled to be at the facility but left to run an errand and was not in the building during the incident. Staff #A stated she prepared breakfast for Resident#1 including oatmeal, eggs, fresh fruit, bagel with peanut butter, water and coffee. She stated she didn't observe the PDA feeding the resident his breakfast that morning. She stated that Resident#1 tended to and choke. She stated Resident #1 had a visitor that morning and then was moved to the facility TV

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room. She stated Resident#1 was sitting in a recliner chair and the PDA was sitting next to him. She stated that Resident #1 preferred to stay in his room and not socialize with other residents, but he would tolerate coming out to the TV room for short periods of time. She stated Resident #1 was not a talkative man and "a man of few words". She stated that she was standing at the kitchen sink, which overlooks the TV room and witnessed Resident #1 coughing and he began to . She stated she ran to the resident and attempted to bend Resident#1 forward as he could not move himself. She stated Resident#1 into her , "not much- had bits of egg, and it was light yellow paste like." She stated she called the Administrator for direction. Staff #A stated the Administrator instructed her and the PDA to move Resident#1 to his room and placed him in bed. Staff #A stated Resident #1 was breathing slowly, so she placed the on the resident. She stated the was in a "green tank" and she turned it on to 3L. She stated Resident #1 was responsive, opened his when she called his name and he answered "yes" quietly. She stated that the Administrator was on "Facetime" (a proprietary videotelephony product) during this time and observed the resident's condition. She stated the Administrator instructed her to call 911 for a change in resident's condition. She stated that she remained on the call with the Administrator and went out of the room to call 911 from another phone. She stated that she started to gather the paperwork that rescue crew would be requesting. She stated the RN arrived and began to assess the resident's condition. She stated she was not in the resident's room when 911 arrived. Staff #A stated that she would need to review Resident#1's medical file to determine if he was a full code status or she could call the Administrator

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A 025	Continued From page 12 to determine code status. In a follow-up interview with facility Staff #A on at 12:05PM after she was confronted by the Administrator about O2 usage for Resident #1, Staff #A stated she had not told the truth when she was interviewed earlier that day. She stated that she had not applied to Resident#1 and when asked who had applied the , she stated the PDA had applied it. Review of Resident #1's Medication Observation Record (MOR) dated indicated no health care order for / treatment. In an interview with the Administrator on at approximately 10AM she stated that Resident #1 was of sound mind, able to make his own decisions and wishes known. She stated Resident #1 was able to move slowly, and able to move his arms and . She stated Resident#1 required assistance with transfers to his wheelchair. She stated Resident#1 was able to feed himself, he moved very slowly but could perform the task. She acknowledged that the PDA was feeding the resident, but when she left, the facility staff would bring him to the dining room for dinner and he would feed himself. She stated it would take time for him to finish but he could feed himself. The Administrator stated that she had concerns with the PDA being distracted on her cell phone and feeding the resident too quickly. The Administrator stated that Resident #1 had had a choking episode earlier in the year and was sent to the hospital for evaluation. She couldn't recall the date and was unable to locate any progress notes for review. She was questioned if Resident #1 required , the Administrator stated that she was unaware of any recent orders but stated that the resident	A 025		

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A 025	Continued From page 13	A 025		

had a history of sleep , and had used , at a previous facility. She stated that he may have brought the with him when he moved in and put it in his closet. When questioned if the facility had a , device to measure SAT, she stated "no." The Administrator stated that Resident #1's care manager may have provided the device. She acknowledged that with regulatory guidelines, facility unlicensed staff are not trained to use a , device. She stated that she had worked , the overnight shift and on the morning of she left the facility to do an errand. She stated that she received a call from Staff A that Resident #1 had choked and a small amount and appeared to be "OK." She stated that she instructed Staff #A to return Resident #1 to his room, put him in bed to be more comfortable. She stated she instructed Staff A to connect to Facetime (a proprietary videotelephony product) so she could observe Resident#1 for herself. She stated that Resident #1 "looked good in bed, he was breathing yet not talking." She stated she instructed Staff A to call 911 to be on the "safe side." The Administrator stated the care manager had called her as she was on her way to the facility. The Administrator stated when she arrived, 911 was already on site working on Resident#1. She stated that she would not necessarily call 911 if a resident just vomits but acknowledged that Resident#1 had a significant change in condition after he choked and . The Administrator stated she was not a licensed medical professional. The Administrator stated that the facility policy is that all resident medical records, including ( ) paperwork is secured in a locked cabinet and the staff have access with a key. The Administrator stated that the staff would need to review the

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A 025	Continued From page 14 resident record to confirm if there is a , there is no other location with quick access to this information. The Administrator stated that Resident #1 was a full code, he had no . Review of the 911 emergency care record for Resident #1 dated indicated the 911 call was received at 12:20 PM and rescue crew arrived at the facility at 12:25 PM and began assessment of Resident #1 at 12:26PM. The report indicates at 12:32 PM, Resident#1 is assessed as unresponsive, his was 0 and rate was 0. The Resident #1 is in and , , ( ) was initiated by 911 crew immediately. Resident #1 was transported to the hospital emergency room (ER). Review of the hospital record for Resident #1 dated at 1 PM, indicated on admission the resident was unresponsive. was noted on the tube inserted by 911. Further review of the record indicates Resident#1 , , on at 7:55PM from anoxic . , , . Class II	A 025		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse	A 165		

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A 165	Continued From page 15 incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to	A 165		

Agency for Health Care Administration

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A 165	Continued From page 16	A 165		

the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The agency may adopt rules necessary to

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A 165	Continued From page 17 administer this section. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to file an adverse incident report with the Agency for 1 of 1 sampled residents (Residents #1) transferred to a more acute care setting for evaluation after experiencing an emergency , , episode. The findings include: Review of facility's medical record revealed that Resident #1 developed a , , emergency requiring hospital care. A review of the Agency's Incident Report Database revealed that no Adverse Incident Report was filed regarding Resident #1's transfer to a higher level of care on . In an interview with the Administrator on at approximately 10 AM she stated that no Adverse Incident Report had been filed for Resident #1,when he required transfer to higher level of care. Refer to A 0025 CLASS III	A 165		

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ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

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

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ˙ , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure Staff A, Staff B and Staff C were listed on the facility's Background Screening Clearinghouse Roster. The findings include: Review of the facility's Background Screening Clearinghouse Employee Roster on at 3 PM and again on revealed Staff A, B and C were not listed as current employees on the facility employee roster. Review of the facility staffing schedule for listed the Administrator, Staff A and Staff B as scheduled for that day. On 12/ at 10 AM the Administrator was informed of the surveyor's findings and stated that she was unaware that Staff A & B were not included on the facility roster. The Administrator	ZZ814		

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ZZ814	Continued From page 2 stated that Staff C was the housekeeper, she believed that Staff C did not needed a background screening. Unclassified	ZZ814		
ZZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ␣ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ␣ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's	ZZ815		

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ZZ815	Continued From page 3 employer or the licensee. (3) All , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts	ZZ815		

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ZZ815	Continued From page 4	ZZ815		

through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(i) Section 817.234, relating to false and fraudulent insurance claims.
(j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
(l) Section 817.505, relating to patient brokering.
(m) Section 817.568, relating to criminal use of personal identification information.
(n) Section 817.60, relating to obtaining a credit card through fraudulent means.
(o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
(p) Section 831.01, relating to forgery.
(q) Section 831.02, relating to uttering forged instruments.
(r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
(s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
(t) Section 831.30, relating to fraud in obtaining medicinal drugs.
(u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
(v) Section 895.03, relating to racketeering and collection of unlawful debts.
(w) Section 896.101, relating to the Florida Money Laundering Act.
If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying

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ZZ815	Continued From page 5	ZZ815		

offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person.

(5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.

(6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who:
1. Does not have an active professional license or certification from the Department of Health; or
2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification.
(b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is

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ZZ815	Continued From page 6 providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining , pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any	ZZ815		

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ZZ815	Continued From page 7	ZZ815		

grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07.
(b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter.
(c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07.
(d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.
(3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965951	A. BUILDING: _____ B. WING _____	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENCREST ALF III	4471 COCONUT CREEK BLVD COCONUT CREEK, FL 33066

(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
ZZ815	Continued From page 8 including , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility to ensure Staff C had a Level 2 background screening prior to entering resident living areas. The findings include: During an unannounced survey on at 8:30 AM, Staff C was observed performing housekeeping tasks. During an interview with Staff C she stated she was the housekeeper, and her responsibilities included cleaning the residents' rooms and the overall facility. She stated that she was "a temporary and was leaving the next day to go home". When asked where was home, she stated Jamaica. Staff C was not seen after the interview. Review of the facility staffing schedule for	ZZ815		

Agency for Health Care Administration

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ZZ815	Continued From page 9 indicated Staff A and Staff B were scheduled 7 AM-7 PM. Staff #C was not on the schedule. In an interview with the Administrator on at 4:30 PM she stated that she believed Staff C did not need a background screen because she did not provide direct care to the residents. She acknowledged that Staff C performed cleaning tasks in residents' personal living spaces. Unclassified	ZZ815		