STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965581	07/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Assisted Living Facility	**504 Third Avenue South Lake Worth, FL 33460**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments
An Assisted Living Facility biennial relicensure survey was conducted on . Crest Manor had deficiencies found at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observations and interviews, the facility failed to honor residents' rights to live in a safe and decent living environment, be treated with consideration and respect and due recognition of personal dignity and need for privacy, and failed to post the Florida Hotline as required.

The findings include:

1) The following observations were made during a tour of the facility conducted beginning at 8:58 AM with the facility Licensed Practical Nurse present:

a. Three community showers located on the second floor had 8.5"x11" signs that read, " Attn Staff, No feces to be left in any shower ".

b. The community shower on the second floor east had a 24"x36" window to the outside with clear glass and no covering. A stairway was located outside the window and was accessible by residents and others. Two other community shower had 12"x18" windows to the hallway with clear glass and no covering.

c. Resident was observed with:
- A stack of paper towels stored on the side of the vanity. A metal paper tower dispenser was observed on the wall above the stack of paper towels. The area around the opening of the paper towel dispenser was observed to be soiled and excessively rusty.

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- Two closet doors had been repaired with raw wooden insets about 2'x2'. They were not sanded or painted to match the rest of the doors and were unsightly. Two residents occupied the one stated the closet doors repairs were not finished; the other stated the raw wood stinks when it gets humid.
- The dresser near the door had four drawers; the third drawer down had a handle that was half-falling off; the bottom drawer had no handle. The resident using the dresser stated, she would like to have it fixed, and would like to use the bottom drawer.
- The vents in the air conditioning unit were excessively dusty.

d. A couch in the hallway outside resident was observed with excessive staning around the arms; the trim was falling off both arms, and brown matter was observed in an area about 1 " x3 " on the center cushion.

e. The required statewide toll-free telephone number for the "Florida Hotline or 800-962-2873" was not posted in full view in a common area accessible to all residents.

These concerns were brought to the Assistant Administrator's attention on .

2) During observational tour of the first and third floors of the facility conducted with the Assistant Administrator, on beginning at approximately 9:05 AM, the following unsanitary concerns and privacy concerns were identified:

a. There were 4 (3.5 ounce) tubes of peri-guard ointment and 3 bottles of peri-wash spray that were located on the window sill in one of the two shower located on the first floor. The Assistant Administrator acknowledged these items were not labeled with individual resident names and were most likely utilized on multiple residents after showers.

b. An 8" X 11" sign was posted on the exterior of the door to that reflected the residents's name and noted staff is to make sure she is wearing her hearing aid. The Assistant Administrator acknowledged this was a privacy related concern for this resident.

c. The 10" X 12" window located in the that is located in the common hallway for #101 and #102 were not covered. The Assistant Administrator acknowledged these windows should be covered to ensure resident privacy.

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d. The 10" X 12" window located in the shower that is located in the common hallway of the 3rd floor shower not covered. The Assistant Administrator acknowledged this window should be covered to ensure resident privacy.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation and interviews, the facility failed to ensure unlicensed staff members who assist residents with self-administration of medications followed required standards of practice for 3 of 3 sampled residents (Residents #12, 13 and 14).

The findings include:

1. Medication systems review was conducted beginning at 11:50 AM. Employee K was observed assisting Residents #12, 13 and 14 with self-administration of medications. For all three residents, she did not bring the medications in their original containers to the residents (or bring the residents to the original medication containers) before removing the prescribed doses, and she did not read the medication labels in the presence of the residents prior to assisting the resident with self-administration of medications.

2. Interviews with three alert and oriented residents revealed the following:

a. On at 9:32 AM, Confidential Resident Interview (CRI) #1 stated Employee B gives him/her medications in the evenings. "She pre-fills multiple residents' pill cups, puts a card with their name on top of each cup, then passes them out all at once while saying, "Here's your medicine." She does not tell them what's in the pill cups."

b. On at 2:03 PM, CRI #2 stated Employee B gives him/her medications in the evenings. "She pulls the med's, puts them in a cup, then loads another one, and another one, and brings them to the people, then she does it again. She says, "Here's yours meds."

c. On at 3:45 PM, CRI #3 stated, "Every night [Employee B] comes by with cup on cup on cup; the cups have a strip with names; She gives it to her in a cup, with a cup of water. Every night [Employee B] will come by with cup on cup on cup." Sometimes they tell her what she is taking.

This was discussed with the facility's Licensed Practical Nurse and Assistant Administrator on at 4:10 PM.

Class III

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0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on record review and interview, it was determined the facility did not ensure that newly hired staff had documentation of a statement from a health care provider, based on examination conducted within past 6 months, that the individual does not have any signs or symptoms of a communicable including for 1 out of 5 sampled employee records reviewed (Employee C).

The findings include:

During employee record review and interview with the Assistant Administrator, conducted on beginning at approximately 12:30 PM, she was asked to locate any documentation from a health care provider for Employee C (direct care staff with a date of hire noted as that indicated she did not have signs or symptoms of a communicable including The Assistant Administrator was unable to locate any documentation to this effect.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observations and interviews, the facility failed to provide a living environment free from hazards, and failed to ensure existing architectural systems and appurtenances were maintained in good working order.

The findings included:

The following observations were made during a tour of the facility conducted beginning at 8:58 AM with the facility Licensed Practical Nurse present:

1. The second floor east community shower numerous signs of interior water damage: the pipe for the fire sprinkler extended around the ceiling and was excessively rusty with paint chipping off and was very unsightly. The baseboards had a moderate amount of black matter in an area about 3 ' long. The ceiling was patched and an area around the light fixture about 24 " x18 " had numerous black spots on it. Observation of the exterior of the building outside and above this black and white streaks 10-20' feet long, and numerous spots of black matter were observed on the outside of the building.

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2. The second floor west community shower a broken marble threshold with two broken pieces of marble about 3"x12" still in the threshold, one was loose; raw concrete was exposed. This was a tripping and safety hazard. A metal pipe extended down from the shower head and ended with a uncapped opening at the bottom, the raw edges of the pipe were a safety hazard. The door jambs were not painted. A plastic and metal chair was being used as a shower chair, the metal portions were completely rusted.

3. The second floor resident revealed:
a. The hand rail in the shower was excessively rusty
b. The fan was located in the ceiling over the shower stall and was very loud and had no cover, exposing the interior of the fixture
c. The light fixture had separated about 1" from the ceiling
d. A towel bar was missing; one of the brackets protruded out; the other bracket was rusty
e. The door revealed wood deteriorating and falling off at the top right corner

4. The resident revealed:
a.The by this the door had two doors. The door trim was missing on the interior for both doors. Raw concrete with dozens of unsightly holes and at least a dozen rusted nails sticking out about 1" were exposed.
b. The rail was not attached to the wall
c. A vent in the had separated from the wall about 1/2"

5. Observation of resident revealed:
a. The wall around the air conditioning electric outlet revealed an unfinished wall repair. The repair had not been sanded or painted
b. The only light in the the two overbed lights. A light fixture above the sink located inside the not turn on. All other resident had a center-light in the ceiling.
c. The wall material on the left side of the sink above the paper towel holder was rippled and cracking.
d. Two towel bars located to the sides of the sink in the excessively rusty; one was repaired with duct tape and was unsightly.
e. A strip of duct tape about 9" long was observed in the back right corner of the sink, and a dark blue strip of paint about 3"x18" was observed along the light blue wall above the light fixture and was unsightly.

5. Rusty metal fixtures for lighting, towel rods and other accessories were observed throughout the second floor.

These concerns were brought to the Assistant Administrator's attention on at 3:30 PM.

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6) During observational tour of the first floor and third floor, conducted with the Assistant Administrator on beginning at approximately 9:05 AM the following concerns were identified:

a. The elevated patio area behind the facility contained a perimeter handrail that was in disrepair. The bottom portion of this railing was completely disconnected. The Assistant Administrator acknowledged this needed to be repaired/replaced.

b. The exterior of the building located on the patio area contained an area that had peeling paint that measured approximately 9' in height by 3' in width. The Assistant Administrator stated a plant used to be attached to the building in that location and when the plant was removed the paint came with it.

c. The glass door of the fire hose box, located near the main dining was missing the glass. The Assistant Administrator stated it was broken more that a month ago.

d. The smoke detector, located outside of the entrance to the dietary department, was wrapped in a tan plastic grocery bag. The Assistant Administrator stated there were contractors working in the area a few days ago and they must have covered it up so as not to get it dirty.

e. The door leading to the patio area, located near the entrance to the dietary department, did not contain a latching mechanism. The Assistant Administrator acknowledged the latching mechanism needed to be replaced.

f. the lower half of the door was missing paneling and contained glue and peeling paint. The Assistant Administrator stated she was not aware how long this door had been in this condition. One of the resident's in this it had been that way for months.

g. The third floor shower a light fixture that was not secured to the ceiling. The Assistant Administrator acknowledged this needed to be secured to the ceiling.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Crest Manor Assisted Living Facility
504 Third Avenue South
Lake Worth, FL 33460

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on . 2013 by a representative from this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene - Davis
Field Office Manager
Division of Health Quality Assurance

AMD/jw
Enclosure

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