STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910406	**05/14/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
CRESTVIEW MANOR	**603 NORTH PEARL STREET CRESTVIEW, FL 32536**	

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

0000 - Initial Comments

On [redacted] through [redacted] an unannounced Biennial survey (with Extended Congregate Care) was conducted at Crestview Manor Assisted Living Facility. At the time of survey there were deficiencies identified.

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation of medication expiration dates, and staff interview the facility failed to dispose of expired meds within 30 days of their expiration date for 3 of 3 residents (#11, #12, and #13).

The findings are:
An observation of the medication carts in the medication [redacted] conducted on [redacted] about 8:50 am. Resident #11 was observed to have medication [redacted] 0.25 mg in the [redacted] drawer. The medication [redacted] had an expiration date of [redacted].
Resident #12 has medication [redacted] 5-325 mg 5 tablets which have an expiration date of [redacted]. While observing the overflow medication cart Resident #12 was also found to have medication [redacted] 5-325mg 90 tablets which expired on [redacted].
The medication [redacted] 1mg tablets were found in the overflow medication cart for Resident #13. She had 3 cards of [redacted] 1mg totaling 90 that expired on [redacted]. She also has another 90 tablets that expired on [redacted] and another 90 expiring on [redacted] which totaled 270 tablets.
Staff Employee A confirmed the expiration dates for the expired medications on [redacted] about 9:10 am. She removed them from the carts.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Crestview Manor
603 North Pearl Street
Crestview, FL 32536

RE: CCR #

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 by representatives of 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 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 surveyors. Should you have any questions please call me at 850-412-4493.

Sincerely,

Donah Heiberg, M.S.W.
Field Office Manager

DH/kc
Enclosure .
XG90

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone:850-412-4540; Fax:(850) 922-9162
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida