RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Crestview Manor
603 North Pearl Street
Crestview, FL 32536

Dear Administrator:

This letter reports the findings of a revisit for a complaint inspection survey conducted on , 2016, by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **ten business days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0091 - 58a-5.0191(12) Fac - Training - Documentation & Monitoring S-S= D

Directed Corrective Actions:

1. The Assisted Living Facility is required to create a policy to address communication with health care providers and family members/ responsible parties following a change of condition. Examples include but not limited to: any condition which required medical attention, including changes in skin condition. The policy should include that the Administrator be notified immediately of any resident change and documentation be made in the medical record of all notifications and any orders or instructions given to the staff. The Administrator must have an active role in determining level of care options for the resident. All direct care staff must be trained on the new policy. Documentation of the training, content and sign-in sheet must be maintained in the facility and available for review by the Agency upon request.
2. The Assisted Living Facility is required to have all residents recieving 3rd party services in the facility reassessed by a health care provider to determine if they are appropriate for continued residency in the facility. This face-to-face assessment by a health care provider must be documented on AHCA form 1823 and maintained in the residents' record. These assessments must be available in the facility for review by the Agency upon request.

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

Crestview Manor
[illegible], 2016

In addition, the responsibility for ensuring the facility can meet the needs of the residents rests with the administrator. The administrator is directed to review each resident's health assessment to ensure they meet residency criteria and their needs can be met at the facility.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Laura Manville, Survey and Certification Support Branch, at (727) 552-1955.

Sincerely,

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

DH/kc

D7JR

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910406	R 11/03/2016
NAME OF PROVIDER OR SUPPLIER **CRESTVIEW MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **603 NORTH PEARL STREET** **CRESTVIEW, FL 32536**	

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

0000 Initial Comments

An unannounced visit was made to Crestview Manor, License #5649, on 11/3/16 for the revisit survey to a complaint survey completed on . Facility failed to comply with directed plan of correction from the Agency and there were deficiencies recited during the revisit.

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0010 Admissions - Continued Residency

Based on record review and staff interview the facility did not re-assess appropriateness of continued care for 3 of 23 residents receiving third party services. (#1, 2 and 3).

The findings are:

The facility received a letter dated which directed the facility to comply with the prescribed steps in order to correct deficient practice:

"All residents receiving 3rd party services in the facility must be reassessed by a health care provider to determine if they are appropriate for continued residency in the facility. This face-to- face assessment by a health care provider must be documented on AHCA form 1823 and maintained in the residents' record. These assessments must be available in the facility for review by the Agency upon request. In addition, the responsibility for ensuring the facility can meet the need of the residents rests with the administrator. The administrator is directed to review each resident' s health assessment to ensure they meet residency criteria and their needs can be met at the facility. This requirement must be met by , 2016."

Resident #1's last Health Assessment Form 1823 was completed in 2015. The resident had been receiving hospice care before the complaint survey. There was no re-assessment completed by the facility to ensure appropriateness of continued care.

Resident #2's last Health Assessment Form 1823 was completed in 2016. The resident had been receiving hospice care before the complaint survey. There was no re-assessment completed by the facility to ensure appropriateness of continued care.

Resident #3's last Health Assessment Form 1823 was completed in 2016. The resident had been receiving care from a home health agency before the complaint survey. There was no re-assessment completed by the facility to ensure appropriateness of continued care.

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	AL11910406	R 11/03/2016
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Interview with the Executive Director on 11/3/16 at 3:20 pm regarding the re-assessments for all three residents receiving third party services indicated that she did not realize she had to complete re-assessments of these residents.

Class III

0091 Training - Documentation & Monitoring

Based on staff interview the facility was not able to provide the required documentation that staff were in-serviced on the new policy developed for residents receiving third party services.

The findings are:

The facility received a letter dated which directed the facility to comply with the prescribed steps in order to correct deficient practice:

"All direct care staff must be trained on the new policy developed for residents receiving third party services. Documentation of the training, content and sign-in sheet must be maintained in the facility and available for review by the Agency upon request. This requirement must be met by , 2016."

On / at 3:00pm the Executive Director (ED) was asked to produce the documentation of the in-service presented to staff on the new policy. She produced two staff files of a staff meeting with their signatures; however, there was no content of the subject matter presented or date it was presented. When asked if there was a sign in sheet for this specific in-service, she stated "no". She then agreed the staff meeting had no date when it was presented and she was not sure if it was presented after the complaint in .

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11910406 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW MANOR	603 NORTH PEARL STREET CRESTVIEW, FL 32536

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0025 Reg. # 429.26(7) FS; 58A-5.0182(1) FAC LSC	Correction Completed	ID Prefix A0028 Reg. # 58A-5.0182(4) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KC	DATE 11/10/16	SIGNATURE OF SURVEYOR Kristi Geml for Margaret Bonnell	DATE 11/10/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO