STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910406	**04/12/2017**
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 re-licensure survey with extended congregate care (ECC) services was conducted at Crestview Manor (License #5649) from to . Deficient practice was found at the time of the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on interviews, and record review, the facility failed to determine the continued appropriateness of continued residency for 1 of 10 sampled residents. (#10)

The Findings:

On at approximately 2:40 pm during the resident interview with resident #10, the question was asked; Tell me about any other services or things the facility could do that would help you? Resident #10 stated that the facility was limited in what they can do to meet his needs. Resident #10 stated that he needed services that would assist with putting on his knee brace. He stated that he had a doctor's order to wear his knee brace and the facility had no one to help him. Resident #10 stated that he could not apply the knee brace by himself and needed assistance with putting it on.

On at approximately 12:13 pm, an interview was conducted with the Facility Director who reported that the facility could not apply the knee brace for resident #10 because there was no staff qualified, and she did not know if he could apply it himself.

A record review of resident #10's medical chart was conducted with the facility director to find an order from Hanger Clinic, with the Licensed Fitter and instructions on how to apply the brace. The instructions stated: Fit and dispense B/L Neoprene Knee or hoses. Clean braces daily, damp cloth, lower strap on knee braces above the belly of the . (See photographic documentation, photo 1). Upon reviewing the order, the facility director confirmed the order and stated she had not noticed the order from Hanger Clinic. She stated that she did not know where the order came from, or who took resident to his appointment on , but it had to have been a facility staff who took him. The facility director stated that she did not have qualified staff to apply the brace and that she did not know the diagnosis for the brace. She stated that resident #10 had not mentioned the knee brace to her, and she had never seen him wearing the brace, and did not know who the doctor was that gave the order for the brace. Stated that she would meet with resident #10, and if he needed the brace, she would not be able to meet his needs at the facility. During this interview contact was made with resident #10's primary physician, and the nurse reported that resident #10's primary doctor did not write an order for the knee brace. Further review of resident #10's medical chart with the facility director revealed that the order was

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written at Baptist Medical Group.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review and interviews the facility failed to provide care and services appropriate to the needs for 1 of 10 sampled residents (#10).

The Findings:

On at approximately 2:40 pm during the resident interview with resident #10, the question was asked; Tell me about any other services or things the facility could do that would help you? Resident #10 stated that the facility was limited in what they can do to meet his needs. Resident #10 stated that he needed services that would assist with putting on his knee brace. He stated that he had a doctor's order to wear his knee brace and the facility had no one to help him. Resident #10 stated that he could not apply the knee brace by himself and needed assistance with putting it on.

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written at Baptist Medical Group.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation of medication observation records (MOR) and staff interview, the facility failed to have an up to date MOR for 1 of 7 (#13) residents observed for medication pass.

The findings are:

Review of the MOR for resident #13 showed he did not have medication . . . 500 mg/ D 200 mg one tablet to give three times daily for . Observation of the MOR shows the medication as not given for 7 am and 12 pm on . There is no explanation on the back of the MOR as to why the medication was not given.

Employee A Med Tech was interviewed on at 2:40 pm. She says that if a resident does not take a medication you are supposed to write on the back explaining why the medication was not given. She then stated, "Yes, I know I forgot . I was supposed to write it in as it happened. She then confirmed there was not explanation on any of the sheets of the MOR. She then pointed out a handwritten note above the medication cart and said this is what we follow. Number 2 states circle meds not given and document on the back why it is not given.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview with the facility director, the facility failed to ensure that 1 of 3 sampled employees (#B) had training for recognizing and reporting resident , neglect, and . , ...

The findings:

On . . . a record review was conducted of employee #B personnel file. Upon review of employee B file there was no documentation or certification that indicated she had received 1 hour training in , neglect and . , . . . within 30 days of hire.

On . . . at approximately 10:52 am, an interview was conducted with the Administrator. During this interview the administrator stated she didn't have a certification for employee B that indicated she had

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received training for , neglect and , within 30 days of hire.

Class III