STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968841	**08/17/2017**
NAME OF PROVIDER OR SUPPLIER **CRESTWOOD HOUSE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **848 CRESTWOOD AVE** **TITUSVILLE, FL 32796**	

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

0000 - Initial Comments

A complaint investigation (2017009157) in conjunction with a re-licensure survey was conducted on , 2017. Crestwood House LLC, license #12735, had deficiencies at the time of the visit related to #2017009157.

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

Based on observations, record reviews, and interviews, the facility failed to document and notify a health care provider and family when 2 of 5 residents (#1 and #5) experienced a significant change, failed to follow a health care provider order for 1 of 6 sampled residents (#5,) and failed to provide care to meet the needs for incontinence care for 1 of 6 sampled residents (#2.)

Findings:

1. Observations made on at 11 am revealed that resident #2 was lying in her bed. A strong smell of was detected in her . When questioned, the administrator said that the last time resident #2 received incontinence care was at 7:30 am that morning. She said a hospice aide came to the facility earlier that morning but was unable to provide care because resident #2 was eating. She said she would go in and clean the resident herself.

Observations made while the administrator provided care revealed that resident #2 had two chux pads and two briefs under her and one chux , between her legs. The chux , between her legs and one of the briefs was saturated with . The administrator said resident #2 a lot because she took the medication .

During an interview with the administrator on at 4:50 pm, she confirmed the findings and said that resident #2 should have received incontinence care earlier than she did.

2. Record review for resident #5 revealed a health assessment form 1823 that was dated on . The form indicated that resident #5 had diagnoses of with rapid rate, , and .

A list of medications was signed by a health care provider and dated on indicated that resident #5 was prescribed 200 milligrams (mg) by mouth twice a day and 3.125 mg by mouth twice a day with meals.

Review of the 2017 Medication Observation Record (MOR) for resident #5 revealed there were

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968841	08/17/2017
NAME OF PROVIDER OR SUPPLIER **CRESTWOOD HOUSE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **848 CRESTWOOD AVE** **TITUSVILLE, FL 32796**	

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

no entries for the and the and no evidence that he was given those medications from -.

During an interview with staff C on at 3:43 pm, he said resident #5 did not receive the medications because a staff member at the office of the health care provider did not call the medications in to the pharmacy.

3. Record review for resident #5 revealed paperwork from a hospital that was dated on . The record did not contain documentation to indicate that resident #5 was sent to the hospital, that a health care provider was notified, and that his family was notified.

During an interview with staff C and the administrator on at 2:33 pm, staff C said that resident #5 was sent to the hospital in , 2017 because he complained of chest pain. The administrator confirmed that it was not documented when resident #5 was sent to the hospital because she thought the hospital paperwork was sufficient documentation.

4. Review of the hospice record for resident #1, revealed she was admitted into hospice care on . Record review for resident #1 revealed there were no notes in the record documenting the significant change, what had transpired causing the need for hospice services and that the family and health care provider were contacted regarding the residents decline in health.

On at 1 PM, the administrator confirmed the findings and said she was not aware she had to document that the resident was admitted to hospice services and that the family and health care provider was aware.

Class III

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

Based on observations and interview, the facility failed to ensure that centrally stored medications were properly secured for 1 of 6 sampled residents (#6.)

Findings:

Upon entering the facility on at 9 am, observations revealed there was an unidentified and unsecured patch on a kitchen counter. The patch appeared to be a medication patch.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968841	08/17/2017
NAME OF PROVIDER OR SUPPLIER **CRESTWOOD HOUSE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **848 CRESTWOOD AVE** **TITUSVILLE, FL 32796**	

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

On at 9:05 am, the administrator confirmed the finding and said the patch was a patch. She said she placed the patch on the kitchen counter because she was going to apply it to resident #6. She then retrieved the original container from a the dining , which was where the resident's medications were centrally stored.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on menu review and interview, the facility failed to obtain regular and therapeutic menus that were reviewed annually by a licensed or registered dietitian,a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards and did not keep the menus that were served on file for 6 months.

Findings:

Review of the menu revealed the Registered Dietitian reviewed the menu on .

On at 10:30 AM, the administrator said she was preparing the menu to send to the Registered Dietitian. She said she used the old menus to prepare the food and the facility did not keep dated menus.

Class III