STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965581	**05/21/2019**
NAME OF PROVIDER OR SUPPLIER **CREST MANOR ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **504 THIRD AVENUE SOUTH** **LAKE WORTH, FL 33460**	

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

0000 - Initial Comments

A Relicensure survey was conducted at Crest Manor Assisted Living Facility on and . The facility had deficiencies at the time of the visit.

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

Based on observation, interview and record review, it was determined that the facility failed to maintain a written record of incidents and/or signficant changes in which the resident required medical attention, for 1 out of 7 sampled residents (Resident #3).

Findings Include:

During interview with Resident #3, on at 10:42 AM, the resident stated that he was attempting to use the restroom one night and his cane caught on the floor (marble thresh-hold at the bathroom door). Resident stated "I hit the cabinet and cracked my ." Additionally, Resident #3 stated: "I tripped over the floor thing (pointing toward the floor and marble thresh-hold at the bathroom door). I feel and hit my on the cabinet. This happened around the 2nd of , I think, it was a little earlier this month. I broke my .

Resident #3 stated that it was not reported initially, but the following day to the Assistant Administrator as he was experiencing , . Resident stated that he was sent to the hospital and was there "for a few days. If there was a grab bar at the door, I could have grabbed on and not ."

During review of Resident #3 file, this surveyor observed the Medication Discharge from (Hospital) documents in file dated . There were no other documents related to the incident observed in the file.

On at 12:42 PM, this surveyor interviewed the Assistant Administrator regarding Resident #3's and hospital visit/stay. The Assistant Administrator stated she knew, and that Resident #3 did not report it right away. She also stated that it was not the reason for him going to the hospital. States Resident #3 was concerned about his Aneurysm. "His girlfriend (name) told me the next morning "You know (Resident #3) last night." Assistant Administrator stated resident #3 didn't want to go to the hospital, but told me that he was concerned about his Aneurysm (thought he had hurt it). So Resident #3 was sent and they kept him.

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This surveyor asked if there was a Discharge Summary from the hospital, or any other documents (related to the incident). The Assistant Administrator turned to the Discharge Medications sheets from (hospital) and stated "This is all the send." This surveyor acknowledged seeing the form in the file, but informed that it does not state why resident #3 presented to the hospital. The Assistant Administrator stated "They only send that, and we have a hard time getting information from the hospitals."

This surveyor also asked how it was known that Resident #3 were and not broken (if there was no information from the hospital). The Assistant Administrator responded "From my notes." This surveyor requested to see the notes, which was provided. This surveyor reviewed the Resident Observation Log provided and observed an entry dated : "Resident was complaining of -aches was sent to Hospital via AMR for further evaluation.

Additionally, this surveyor observed a second entry dated : "Resident return to facility from hospital, has orders to follow up with Primary Care and surgeon." . These were the only two entries related to the incident observed/provided.

This surveyor and Team Coordinator (TC) informed the Assistant Administrator of their responsibility to secure information from the hospital, which was acknowledged. And that the facility is responsible for completing a report for incidents occurring at the facility, which was not done/available at the time of the survey.

During the Exit Interview on at 1:55 PM - 2:12 PM, aforementioned was discussed. The Administrator acknowledged the findings.

Class III

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

Based on record review and interview, the facility failed to ensure that all staff received the required in-service training's within 30 days of hire for 1 of 4 sampled staff (Staff D).

The Findings Included:

On at approximately 111:00AM, a employee record review was conducted for Staff D and revealed Staff D's hire date as , and she works as a Home Health Aide on the 3PM - 11PM shift. Further review revealed no certificate of completion for the following in-service:

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

1) Elopement Response Training

During an interview with the Administrator on [redacted] at 1:30PM, the findings were acknowledged and no additional documentation was provided for review.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure that all staff received the required in-service training's within 30 days of hire for 1 of 4 sampled staff (Staff D).

The Findings Included:

On at approximately 11:00AM, a employee record review was conducted for Staff D and revealed Staff D's hire date as [redacted], and she works as a Home Health Aide on the 3PM - 11PM shift. Further review revealed no certificate of completion for the following in-service:

1)

During an interview with the Administrator on at 1:30PM, the findings were acknowledged and no additional documentation was provided for review.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to maintain an environment free of hazards for all residents. The facility also failed to ensure that all furniture was in good repair.

Findings Include:

On at approximately 10:10AM during the observational tour several chairs in the dining room area was observed in disrepair with peeling paint and torn cushions. Also in the dining room, the floor by the exit to the patio is in disrepair with scratches and discoloration. Further review revealed on the 3rd and 4th Floor there were chairs in disrepair observed. Inside the elevator, the tile on the floor is in disrepair with sections missing.

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During Exit Interview at 1:55 PM - 2:12 PM, the findings regarding the Physical Plant was discussed.

Class III

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on observation, record review and interview, the Center failed to ensure that the Attestation form was completed/or in the file for one (1) of two (2) employees reviewed (Employee B).

Findings Include:

On - a Re-licensure Survey conducted at the facility. During the Re-licensure Survey conducted on , this surveyor performed a review of the facility's employee files. During review of Employee B's file, this surveyor observed that the Attestation of Compliance with Background Screening Requirements (Attestation) document was not in employee B file.

On /2109, this surveyor interviewed the Assistant Administrator, and requested the Attestation form for Employee B. The Assistant Administrator reviewed the file and was unable to locate the document; then stated they did not have it.

On between 2:10 PM and 2:25 PM, this surveyor and the Team Coordinator met with the Administrator, and both Assistant Administrators to conduct the Exit Interview. The findings of the visit, including the absence of a completed/signed Attestation of Compliance form for Employee B. The Administrator acknowledged the finding and stated they will correct it.

Class