STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910406	06/05/2019
NAME OF PROVIDER OR SUPPLIER **CRESTVIEW MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **603 NORTH PEARL STREET** **CRESTVIEW, FL 32536**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced Biennial survey with Extended Congregate Care Services (ECC) was conducted at Crestview Manor on and . A complaint survey for allegations contained within complaint numbers 2019007725 & 2019006197 was conducted in conjunction. Deficient practice was identified at the time the survey.

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

Based on observation, record review and interview, the facility administrator failed to conduct resident assessments to determine appropriateness of continued residency after the initiation of for 2 of 16 residents reviewed (#5 & #53).

The findings include:

On at 10:45AM, entrance was made to the facility for the purposes of completing a standard survey, to review Extended Congregate Care services and to review two complaints filed with the Agency in reference to the facility. At the time of entrance, Resident #53 was observed to be in the hallway seated in a geri-chair with a , tray secured in front of her, preventing her from exiting the chair. The resident was seated in the chair in the hallway across from the employee break room and was not reclined, causing her to be dangling in the air approximately inches off the floor. The resident was significantly and stayed in the geri-chair until surveyor departure around 5:00PM on .

On at 12:00PM, an observation of the facility's lunch meal service was conducted. Resident #5 was observed to be wheeled into the dining room by a staff member and placed next to one of the doorways leading into the dining room. Resident #5 was observed to be in a geri-chair that had a , tray locked in place in front of the resident, keeping the resident secured in the chair. Resident #5 was also significantly .

On , entrance was made to the facility around 8:30AM to continue the survey process. Surveyors were seated at a table in the employee breakroom, which was open to a primary hallway in the facility. Around 9:00AM, staff members brought both Resident #5 and Resident #53 into the hallway directly across from the employee breakroom. Both residents were observed to be in their geri-chairs with , trays in front of them that were secured to their chairs, preventing the residents from removing the trays and preventing the residents from rising out of the chairs at will. Neither resident was able to remove the tray from the chair. Again, Resident #53 was observed not to be reclined and her were dangling in

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the air approximately inches off the ground. Both residents stayed in the chairs until they were gotten and taken to the dining room for lunch, and then staff returned them to the same spot in the hallway where they sat for several more hours after lunch.

Review of the medical record for Resident #53 showed a Resident Health Assessment, Form 1823, dated , describing a decline in the resident's cognition. The form stated the resident was to use a 4 wheel rollator walker for ambulation and was a risk, so required staff assistance. Continued review of her chart showed Resident Observation Records that indicated the resident had experienced multiple over the past several months including on , , and . The on resulted in the resident obtaining a small . There was no evidence this resident had been reassessed for continued residency.

Review of the medical record for Resident #5 showed a Resident Health Assessment, Form 1823, dated , that indicated the resident had of the and required total assistance with all Activities of Daily Living (ADLs).

On at 10:00AM, an interview was conducted with the facility manager, who confirmed the residents were restrained at that time and the chairs with trays were being used because of the residents' unsafe behaviors.

Class II

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

Based on interview, contract review and record review, the facility failed to appropriately supervise the health, safety and general whereabouts of 1 of 12 residents (#13) by allowing the resident to leave the facility on 3 separate occasions without having him sign-out and without facility staff knowing he had left the facility.

The Findings Include:

On at 4:50PM, an interview was conducted with Staff #D. During interview Staff #D revealed that she had never been involved in any drills, and definitely not an elopement drill. She also said that about a month or so ago, one of the residents (#13) had been brought to the facility by the police and no one had known he was gone. She stated he had been found about miles away from the facility and it had been hot that day.

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Review of the medical record for Resident #13 showed a Resident Health Assessment, Form 1823, dated , that showed the resident had physical and sensory limitations including generalized , and being severely hard of hearing. He was also noted on the assessment to be at risk for and for elopement.

Review of the resident observation forms in the resident's chart showed the resident had eloped on , and .
The resident observation note for stated: staff came by and said she saw the resident out walking on a nearby boulevard. She said she cut through the parking lot and figured she would see him, but didn't. Another staff went out while others went out front to look for him. The note further indicated the resident had turned around and was found in the parking lot. When they asked him where he was going, he stated that he wanted to know what highway that was.

The resident observation note for stated: Staff called and stated she saw Resident #13 at the lights on 85. Staff went to go get the resident.

The resident observation note for stated: The medication technician got a phone call from the police department saying they thought they had one of the facility's residents, which was Resident #13. They stated he had been found on highway 90 by a park. The police officer stated that he and emergency medical services had responded to the resident at that location as he had almost been hit by a car.

Review of the resident's contract with the facility showed a section labeled "SECURITY" on page 4 of 4 that stated: Residents who have been identified at risk of must be enrolled in Project Life Saver. A tracking device with a GPS is attached by a bracelet and the monthly fee is the responsibility of the resident or sponsor.

On at 4:03PM, an interview was attempted with Resident #13. The resident was severely hard of hearing and did not do very well with reading , either. He was asked how things were going with his stay in the facility, but he was not able to hear me or read my , . Finally I got him to understand the question "how long have you been here?" and he stated, "125 days." When compared to his admission date, the length of stay he provided seems to be accurate; however, cognition is difficult to determine due to his inability to hear and understand even the most basic questions.

On at 4:10 PM, an interview was conducted with the facility manager, who stated Resident #13 was not an elopement risk, as he didn't have . The facility manager was presented with the resident's record and asked to review his Resident Health Assessment, Form 1823. After she reviewed

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the document, she stated, "we missed that he was an elopement risk." She further stated that the resident really liked Burger King and would often leave the facility on his own to go get himself a burger and didn't stay gone long. She also stated the resident had a wheelchair but didn ' t really use it, nor did he sign himself out or in like he was supposed to, but stated they didn't stop him from leaving, as that was a resident right in an Assisted Living Facility (ALF). She said the resident didn't have and confirmed that she did not report the incidents documented in the resident's chart to AHCA as an elopement. She went on to state that on , the resident had just went farther, too far that time, and the sheriff's department had called and brought him . She also admitted that they did not know he had left the facility. She confirmed that the resident was severely hard of hearing, and Adult Protective Services (APS), who admitted him, were going to get him . The facility manager revealed APS had assessed Resident#13, but did not feel he needed the tracking device, but confirmed that the assessment was not documented in the resident's record.

Class II

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observation and record review, the facility staff failed to ensure 1 of 2 residents (#5) received assistance with eating in accordance with their assessed need for assistance.

The Findings Include:

On at 12:00PM, an observation of the facility's lunch meal service was conducted. Resident #5 was wheeled into the dining room by a staff member and placed next to one of the door ways leading into the dining room. The resident was observed to be in a geri-chair that had a , tray locked in place in front of the resident, keeping the resident secured in the chair.

The staff were then observed to bring the resident's plate into the dining room and sit it on the , tray in front of the resident. The resident made no effort to feed herself and staff made no effort to assist the resident. The resident seemed and was talking aloud during the meal service; however, her speech was garbled and incoherent. The resident was observed to sit in the dining room for 20 minutes with her food tray in front of her and no assistance was provided to the resident during that period of time. There was another resident observed to be seated at a table with her husband right next to Resident #5. This resident was observed several times encouraging Resident #5 to eat; however, resident #5 never attempted to feed herself.

Review of the Resident Health Assessment, Form 1823, dated , for Resident #5 showed the

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resident required "total care with activities of daily living (ADLs)" and required assistance with eating.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation and interview, the facility failed to ensure they protected the rights of the residents by ensuring physical weren't used in the facility for 2 of 60 residents (#5 & #53) who were observed to be restrained in geri-chairs with , trays and by failing to investigate an allegation of potential for 1 of 12 residents (#53).

The Findings Include:

:
On at 10:45AM, entrance was made to the facility for the purposes of completing a standard survey, to review Extended Congregate Care services and to review two complaints filed with the Agency in reference to the facility. At the time of entrance, Resident #53 was observed to be in the hallway seated in a geri-chair with a , tray secured in front of her, preventing her from exiting the chair. The resident was seated in the chair in the hallway across from the employee break room and was not reclined, causing her to be dangling in the air approximately inches off the floor. The resident was significantly and stayed in the geri-chair the rest of .

On at 12:00PM, an observation of the facility's lunch meal service was conducted. Resident #5 was observed to be wheeled into the dining room by a staff member and placed next to one of the doorways leading into the dining room. Resident #5 was observed to be in a geri-chair that had a , tray locked in place in front of the resident, keeping the resident secured in the chair. Resident #5 was also significantly .

On , entrance was made to the facility around 8:30AM to continue the survey process. Surveyors were seated at a table in the employee breakroom, which was open to a primary hallway in the facility. Around 9:00AM, staff members brought both Resident #5 and Resident #53 into the hallway directly across from the employee breakroom. Both residents were observed to be in their geri-chairs with , trays in front of them that were secured to their chairs, preventing the residents from removing the trays and preventing the residents from rising out of the chairs at will. Neither resident was able to remove the tray from the chair. Again, Resident #53 was observed not to be reclined and her were dangling in the air approximately inches off the ground. Both residents stayed in the chairs until they were gotten

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and taken to the dining room for lunch, and then staff returned them to the same spot in the hallway where they sat for several more hours after lunch.

On at 10:00AM, an interview was conducted with the facility manager, who confirmed the residents were restrained at that time and the chairs with trays were being used because of the residents' unsafe behaviors.

Allegations of :
Review of the medical record for Resident #53 showed a Resident Observation Note dated that stated: Resident has a large on her . Was told first shift (resident aide) rubs the resident's in the morning to get her up. There was a note under this statement, written in a different ink and handwriting, that stated: "nurse came in was reported she actually had a the night before. As we spoke to her she said she got up did not report it to anyone." There was no documentation in the chart to indicate this resident had suffered a the night before; however, there were several notes including entries on , , , and all showing the resident had been found on the floor after suffering a and had to be assisted up off the floor.

On at 10:48 AM, an interview was conducted with Staff A, resident aid. She was asked if Resident #53 , could she get herself off the floor and into bed without assistance and the resident aide stated, "No."

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(l)

Based on interview, contract review and record review, the facility failed to be generally aware of the location for 1 of 12 residents (#13) identified for risk of elopement at all times by allowing the resident to leave the facility on 3 separate occasions without signing-out and without staff knowing he had left the facility and failed to conduct resident elopement drills at least twice in the past year.

The Findings Include:

On at 4:50PM, an interview was conducted with Staff #D. During interview Staff #D revealed that she had never been involved in any drills, and definitely not an elopement drill. She also said that about a month or so ago, one of the residents (#13) had been brought to the facility by the police and no one had known he was gone. She stated he had been found about miles away from the

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facility and it had been hot that day.

Review of the medical record for Resident #13 showed a Resident Health Assessment, Form 1823, dated , that showed the resident had physical and sensory limitations including generalized , and being severely hard of hearing. He was also noted on the assessment to be at risk for and for elopement.

Review of the resident observation forms in the resident's chart showed the resident had eloped on , and .
The resident observation note for stated: staff came by and said she saw the resident out walking on a nearby boulevard. She said she cut through the parking lot and figured she would see him, but didn't. Another staff went out while others went out front to look for him. The note further indicated the resident had turned around and was found in the parking lot. When they asked him where he was going, he stated that he wanted to know what highway that was.

The resident observation note for stated: Staff called and stated she saw Resident #13 at the lights on 85. Staff went to go get the resident.

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Review of the resident ' s contract with the facility showed a section labeled "SECURITY" on page 4 of 4 that stated: Residents who have been identified at risk of must be enrolled in Project Life Saver. A tracking device with a GPS is attached by a bracelet and the monthly fee is the responsibility of the resident or sponsor.

On at 4:03PM, an interview was attempted with Resident #13. The resident was severely hard of hearing and did not do very well with reading , either. He was asked how things were going with his stay in the facility, but he was not able to hear me or read my , . Finally I got him to understand the question "how long have you been here?" and he stated, "125 days." When compared to his admission date, the length of stay he provided seems to be accurate; however, cognition is difficult to determine due to his inability to hear and understand even the most basic questions.

On at 4:10 PM, an interview was conducted with the facility manager, who stated Resident #13

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was not an elopement risk, as he didn't have . The facility manager was presented with the resident's record and asked to review his Resident Health Assessment, Form 1823. After she reviewed the document, she stated, "we missed that he was an elopement risk." She further stated that the resident really liked Burger King and would often leave the facility on his own to go get himself a burger and doesn't stay gone long. She also stated the resident had a wheelchair but didn't really use it, nor did he sign himself out or in like he was supposed to, but stated they didn't stop him from leaving, as that was a resident right in an Assisted Living Facility (ALF). She said the resident didn't have and confirmed that she did not report the incidents documented in the resident's chart to AHCA as an elopement. She went on to state that on , the resident had just went farther, too far that time, and the sheriff's department had called and brought him . She also said that they did not know he had left the facility. She confirmed that the resident was severely hard of hearing, and Adult Protective Services (APS), who admitted him, were going to get him . The facility manager revealed APS had assessed Resident#13, but did not feel he needed the tracking device, but confirmed that the assessment was not documented in the resident's record. She was also not able to provide any evidence that elopement drills had been conducted with facility staff.

Class II

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation and interview, the facility lead medication technician (MT) failed to read the medication labels aloud to the resident and failed to adhere to accepted standards of control when assisting residents with self-administration of medication.

The findings include:
On at 8:01 AM, an observation of assistance with medication administration was conducted with the lead medication technician, Employee C. The medication technician stood in front of the medication cart as a resident approached the cart. She identified the resident, and then began to gather the resident's packed medications from the medication cart. She was then observed to pop the resident's pills out of the pack, using her bare , and was observed touching the pills with her to encourage them to come out of the pack and into a paper medication cup. As she did this, she would tell the resident, "this pill is for , " instead of reading the medication label to the resident or telling the resident the name of the medication. She also stated to the resident, "you take a lot of pills." During medication assistance with this resident, Employee C only read aloud one medication label out of the 12 medications pulled (, 81 mg). After all the resident's pills had been placed in the medication cup, Employee C was asked to count and confirm the total number of medications being provided for the resident. She then proceeded to place all the pills in her bare

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and count the pills into the medication cup.

While in the medication room, there was also a large sharps container observed on the floor next to one of the medication carts. The container had two holes on the top, both with lids that covered them when not in use. One side of the container, the larger side, was observed to be open with a hole large enough to place both of your in at the same time. Used syringes, , , lancets, and other sharps instruments with visible on them were observed in the sharps container

On at 11:10AM, Employee C was asked about the sharps container on the floor and stated they would take it to the biohazard room once filled. When asked about the concern with the larger section being open, she replied, "its like that so they can put their strips and lancets in there when done." When asked if she had any concerns about residents accidentally sticking themselves with such a large portion of the container open, she stated, "all residents that take their are all in their good mind. They know not to stick their in there."

Class III

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

Based on observation and interview, the facility failed to ensure over-the-counter (OTC) medications were appropriately stored.

The Findings Include:

On at 11:01 AM an initial tour of the facility was conducted. There were multiple storage rooms throughout the facility that were noted to be unlocked and easily opened by anyone passing by them. In one of the storage rooms, close to #, there was a gift type bag observed with what appeared to be a resident's personal items that included two bottles of pills that were labeled as a homeopathic type medicine (Photographic Evidence Obtained).

On at 2:47 PM, the maintenance man and the facility manager were escorted to the storage closet where the OTC medications had been observed. The facility manager confirmed the over the counter medications were not stored properly.

Class III

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0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on record review and interview, the facility failed to notify the Agency for Health Care Administration (AHCA) of a change in administrator within the required 10 days.

The findings include:

Review of the website FloridaHealthFinder.gov (https://www.floridahealthfinder.gov) on identified the facility administrator as Employee F.

During a resident interview (resident #24) conducted on , at approximately 2:00 PM, the resident stated, "Employee F in ." The resident provided a copy of the obituary for Employee F, which showed she had , on .

During an interview with the facility manager conducted on , at approximately 4:00 PM, the facility manager confirmed that the administrator had in . The facility manager provided a copy of a letter, dated , , appointing Employee G as the new administrator. The letter stated, "Employee F , on . I was appointed by the duly elected Board of Directors to assume her position on . The notice to AHCA of Change of Administrator is in process," and was signed by Employee G.

A telephone interview was conducted on , at approximately 2:40 PM, with the Agency for Health Care Administration (AHCA) Assisted Living Facilities (ALF) Unit and they were asked to supply confirmation that the agency had been notified of the change in administrator. An email from the AHCA representative showed the facility had not notified the Agency of the change in administrators until .

Class III

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

Based on interview and record review, the facility failed to maintain menus that ensured meals met the nutritional standards established by the USDA Dietary Guidelines for Americans by failing to include a nutritional breakdown of the planned menus.

The findings include:

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Review of the facility dietary menus showed planned menus for a total of 13 weeks. These menus listed the foods that would be provided to the residents at breakfast, lunch and dinner. At the bottom of the menus, there was a guide to portion sizes that should be used to serve menu items to the residents as well as the signature of a registered dietitian (RD) with a date of .

The menus were not observed to have any breakdown of the nutritional values of the food items listed for service that would indicate the menus were created in accordance with the USDA Dietary Guidelines.

Interview on at approximately 1:20 PM, with the kitchen manager, revealed they had no other menus than what had already been provided for review.

The facility manager was then asked to provide the contact information for the RD, but stated she did not have the dietitian's contact number and would have to call the facility's corporate office to obtain that information. Several minutes later, she returned and stated the corporate office had also been unable to locate contact information for the dietitian.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to appropriately notify the Agency for Health Care Administration of adverse elopement incidents for 1 of 12 residents (#13) after he left the facility on 3 separate occasions without staff knowing he was gone.

The Findings Include:

On at 4:50PM, an interview was conducted with Staff #D. During interview Staff #D revealed that she had never been involved in any drills, and definitely not an elopement drill. She also said that about a month or so ago, one of the residents (#13) had been brought to the facility by the police and no one had known he was gone. She stated he had been found about miles away from the facility and it had been hot that day.

Review of the medical record for Resident #13 showed a Resident Health Assessment, Form 1823, dated , that showed the resident had physical and sensory limitations including generalized , and being severely hard of hearing. He was also noted on the assessment to be at risk for and for elopement.

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Review of the resident observation forms in the resident's chart showed the resident had eloped on , and .
The resident observation note for stated: staff came by and said she saw the resident out walking on a nearby boulevard. She said she cut through the parking lot and figured she would see him, but didn't. Another staff went out while others went out front to look for him. The note further indicated the resident had turned around and was found in the parking lot. When they asked him where he was going, he stated that he wanted to know what highway that was.

The resident observation note for stated: Staff called and stated she saw Resident #13 at the lights on 85. Staff went to go get the resident.

The resident observation note for stated: The medication technician got a phone call from the police department saying they thought they had on of the facility's residents, which was Resident #13. They stated he had been found on highway 90 by a park. The police officer stated that he and emergency medical services had responded to the resident at that location as he had almost been hit by a car.

Review of the resident ' s contract with the facility showed a section labeled "SECURITY" on page 4 of 4 that stated: Residents who have been identified at risk of must be enrolled in Project Life Saver. A tracking device with a GPS is attached by a bracelet and the monthly fee is the responsibility of the resident or sponsor.

On at 4:03PM, an interview was attempted with Resident #13. The resident was severely hard of hearing and did not do very well with reading , either. He was asked how things were going with his stay in the facility, but he was not able to hear me or read my , . Finally I got him to understand the question "how long have you been here?" and he stated, "125 days." When compared to his admission date, the length of stay he provided seems to be accurate; however, cognition is difficult to determine due to his inability to hear and understand even the most basic questions.

On at 4:10 PM, an interview was conducted with the facility manager, who stated Resident #13 was not an elopement risk, as he didn't have . The facility manager was presented with the resident's record and asked to review his Resident Health Assessment, Form 1823. After she reviewed the document, she stated, "we missed that he was an elopement risk." She further stated that the resident really liked Burger King and would often leave the facility on his own to go get himself a burger and didn't stay gone long. She also stated the resident had a wheelchair but didn't really use it, nor did he sign himself out or in like he was supposed to, but stated they didn't stop him from leaving, as that was a resident right in an Assisted Living Facility (ALF). She said the resident didn't have and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910406	**06/05/2019**
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)

confirmed that she did not report the incidents documented in the resident's chart to AHCA as an elopement. She went on to state that on , the resident had just went farther, too far that time, and the sheriff's department had called and brought him . She also said that they did not know he had left the facility. She confirmed that the resident was severely hard of hearing, and Adult Protective Services (APS), who admitted him, were going to get him . The facility manager revealed APS had assessed Resident#13, but did not feel he needed the tracking device, but confirmed that the assessment was not documented in the resident's record.

Class III